Health Care Financing

Status Report

Research and Demonstrations in Health Care Financing
April 1985 Edition

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Health Care Financing Administration

Health Care Financing

Status Report

The Office of Research and Demonstrations (ORD), Health Care Financing Administration (HCFA), directs more than 300 research, evaluation, and demonstration projects. A central focus is on program expenditures as they relate to reimbursement, coverage, eligibility, and management alternatives under Medicare and Medicaid. Study activity also examines program impact on beneficiary health status, access to services, utilization, and out-of-pocket expenditures. The behavior and economics of health care providers and the overall health care industry are also topics of investigation.

These activities are carried out by three major components—the Office of Research, the Office of Demonstrations and Evaluations, and the Office of Operations Support. The Office of Research conducts and supports data collection efforts and research on health care providers, reimbursement, beneficiary behavior, and health care utilization. The Office of Demonstrations and Evaluations funds, manages, and evaluates pilot programs that test new ways of delivering and financing Medicare and Medicaid services. The Office of Operations Support provides ORD-wide administrative direction for its research, demonstration, and evaluation projects, which includes the budget and accounting operations; grants, cooperative agreements, and contracts-award process; and publications and information resources program.

This report provides basic information on active intramural and extramural projects in a brief format. These projects are used to assess new methods and approaches for providing quality health care while containing costs, and they often provide the basis for making critical policy decisions on health care financing issues.

Projects are arranged according to ORD budget priority areas and subject categories. The synopsis on each project includes the title, project number, project period, name and address of awardee, contractor, or grantee organization, Federal project officer with primary responsibility for the project, a brief description, and the status of the project as of December 31, 1984. When a project involves research and development funds, the total funding amount for the life of the project is included. Remaining extramural projects are being conducted with waivers that permit innovations to financing and delivery of health services under the Medicare and Medicaid programs.

This is the fifth edition of the *Status Report.* Updated editions will be produced on an annual basis. The information presented should be of use to policy officials, health planners, and researchers in examining the range of research and demonstration activities that are undertaken by ORD and the implications of results and findings.

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Health Care Financing

Status Report

Research and Demonstrations
in Health Care Financing

U.S. Department of Health and Human Services
Health Care Financing Administration
Office of Research and Demonstrations
Baltimore, Maryland
April 1985

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Inpatient General

Hospital Costs and the Reduction of Excess Hospital Capacity

Project No.:	95-P-97526/5-02
Period:	December 1979 - September 1984
Funding:	$ 447,080
Award:	Grant
Grantee:	Michigan Office of Health and Medical Affairs P.O. Box 30026 Lewis Cass Building Lansing, Mich. 48909
Project Officer:	Joe Cramer Division of Hospital Experimentation

Description: This project grew out of concerns of labor and industry organizations involved in paying for medical care. By eliminating excess hospital beds, health care costs could be reduced. A Governor's task force was formed to address the financial, legal, and employment-related issues involved in hospital closures. Legislation was passed to require the development of bed-reduction plans. It was anticipated that 3,800 acute-care hospital beds might be eliminated over the life of the program. Under the demonstration, the Michigan Hospital Capacity Reduction Corporation (HCRC) was responsible for reviewing proposals from hospitals and approving specific reimbursement waivers related to capacity-reduction activities. All third-party payers were expected to participate.

Status: Six health systems agencies with excess beds developed hospital-specific, bed-reduction plans that were updated on an ongoing basis. A Hospital Capacity Reduction Corporation was established in January 1981 to facilitate hospital capacity reduction. After much negotiation, the Health Care Financing Administration (HCFA) approved, for 1 year, Michigan's request to consider waivers of selected Medicare reimbursement policies on a project-by-project basis to facilitate hospital capacity reduction. Michigan accepted all of HCFA's terms and conditions. Prior to terminating participation in the HCRC program on September 30, 1984, HCFA agreed to limited participation in two closure projects--New Plymouth Road General and Hutzel Health Center, Warren. The draft final report from this project was received in January 1985.

Reducing Inappropriate Use of Inpatient Medical, Surgical, and Pediatric Services--Extension of the Appropriateness Evaluation Protocol

Project No.: 18-C-98317/1-02
Period: May 1983 - December 1985
Award: Cooperative Agreement
Awardee: University Hospital, Inc.
75 East Newton Street
Boston, Mass. 02118
Project Officer: Sherry A. Terrell
Division of Reimbursement and Economic Studies

Description: The purpose of this cooperative agreement is to revise the Appropriateness Evaluation Protocol (AEP) to deal with two concerns: the problem of surgical admissions which should be performed on an outpatient basis, and the problem of indications for performance of surgical procedures. The grantee will also conduct a formal experimental trial of the effectiveness of educational feedback of AEP results to hospital administrators and physicians on lowering levels of inappropriateness.

Status: Criteria development for inpatient and outpatient surgical location and timing has been completed, and validity and reliability trials are in progress. In addition, data collection in eight Massachusetts hospitals has begun and will continue through mid-year. Feedback is being provided to administrative and medical staffs on a physician-specific basis at participating hospitals.

An Independent Evaluation of the Reliability of the Standardized Medreview Instrument

Project No.: HCFA-84-1099
Period: July 1984 - June 1985
Funding: $ 9,500
Award: Contract
Contractor: Warren S. Blumenfeld
Georgia State University
College of Business Administration
University Plaza, S.E.
Atlanta, Ga. 30303
Project Officer: Sherry A. Terrell
Division of Reimbursement and Economic Studies

Description: The purpose of this project is to critically evaluate the reliability of the Standardized Medreview Instrument (SMI), a medical utilization review methodology. The instrument will be assessed using the Standards for Educational and Psychological Testing of the American Psychological Association (APA).

Status: The analysis of the SMI has begun using APA guidelines. Preliminary examination indicates that the construct and content validity is satisfactory. In addition, interrater reliability and instrument reliability will also be examined. A final report is expected in June 1985.

Appropriateness of Hospitalization: A Comparative Analysis of Reliability and Validity of the Appropriateness Evaluation Protocol and the Standardized Medreview Instrument

Project No.: 18-C-98582/5-01
Period: July 1984 - January 1986
Funding: $ 306,342
Award: Cooperative Agreement
Awardee: Michigan Health Care Education and Research Foundation, Inc.
600 Lafayette East
Detroit, Mich. 48226
Project Officer: James Beebe
Division of Beneficiary Studies

Description: The purpose of this research is to assess the relative reliability and validity of the Appropriateness Evaluation Protocol (AEP) and the Standardized Medreview Instrument (SMI) in identifying the appropriateness of medical, surgical, and gynecological admissions and days of stay in acute-care hospitals. The AEP was developed by Boston University and the SMI by Systemetrics, both under HCFA funding. A second focus is to estimate Michigan rates of inappropriate care and how these rates are related to hospital characteristics and patient characteristics.

Status: Sample hospitals have been identified and letters requesting cooperation have been mailed. Training classes for nurses who will administer the instruments began in January 1985.

Longitudinal Studies of Local Area Hospital Use

Project No.: 18-C-98512/5-01
Period: July 1984 - July 1987
Funding: $ 214,290
Award: Cooperative Agreement
Awardee: University of Michigan
3014 Administrative Building
Ann Arbor, Mich. 48109
Project Officer: John C. Langenbrunner
Division of Reimbursement and Economic Studies

Description: This project will pursue longitudinal studies of local area hospital use in Michigan, tracing the 1980-82 recession, revisions to Medicare, the development of capitation and other incentive systems, and other factors affecting hospital use. Beginning in 1978, under previous Health Care Financing Administration funding, acute hospital use for 60 market-defined service areas in Michigan's lower peninsula (10 million persons) was identified and studied. Beginning in 1980, comprehensive hospitalization data have been collected annually on this population and will continue indefinitely. The data source available (Michigan inpatient-data base) includes all use and can be subdivided by age and expected source of payment. Previous studies of these subgroups have indicated strong associations across groups. Analyses of the data will include:

- Changes in Medicare discharge rates, before and after adjustments for population and provider characteristics.
- Changes in the access characteristics associated with changes in the Medicare rates and population characteristics.
- Changes in the community-wide, Medicare, and non-Medicare discharge rates associated with growth of capitation and preferred provider organization payment.

This project was funded because continued study of Michigan will add to the conceptual understanding of hospital use, yielding theories testable elsewhere. No opportunity for a longitudinal study of a mixed rural and urban population of several million has existed before. This research will examine the stability of market areas, trends in hospital use measures, and the relationships to external socioeconomic factors. Findings could suggest several improvements in public and private policies to control hospital care costs.

Status: The research data bases for the years 1981 and 1982 have been successfully constructed. The data bases for the years 1983 and 1984 are expected to be available by June 1985. A final report for this project is expected in July 1987.

Further Analysis of a Proposed Elimination of a Medicare Offset of Hospital Part B Losses With Surpluses Generated Under Part A

Description: Two studies, one by contract and one intramural, are examining the potential effects of a proposal for eliminating two regulatory adjustments to Medicare's reimbursement of the lesser of costs or charges to hospitals:

- The provision for aggregate calculation of the lesser of costs or charges between inpatient (Part A) and outpatient (Part B) hospital services (rather than keeping the calculations separate between Part A and Part B hospital services).

- The provision allowing providers to carry forward unreimbursed costs (any negative sum of Part A plus Part B cost minus charge differences) to subsequent years to a time when costs exceed charges.

With the implementation of the prospective payment system and the consideration of this proposed change by the House Ways and Means Committee, the Office of Legislation and Policy and the Bureau of Eligibility, Reimbursement, and Coverage have requested the Office of Research and Demonstrations to make national estimates of the anticipated impact on the Medicare budget and to furnish an analysis of the impact of the proposed changes on the Nation's hospitals, with particular emphasis on public hospitals and teaching hospitals.

Project No.: 84-0955
Period: June 1984 - December 1984
Funding: $ 9,500
Award: Contract
Contractor: Applied Management Sciences
962 Wayne Avenue
Silver Spring, Md. 20910
Project Officer: J. Michael Fitzmaurice
Division of Reimbursement and Economic Studies

Status: This project was undertaken on a rapid-turnaround basis under a purchase order to a contractor with substantial experience with such need for speed. The preliminary estimates were done within 1 week of contract award. The project was completed in September 1984.

Funding: Intramural
Project Director: J. Michael Fitzmaurice
Division of Reimbursement and Economic Studies

Status: This study reveals that, in 1980, 20 percent (196) of a sample of 984 hospitals used an excess of inpatient charges over costs to offset outpatient losses (charges less than costs). The range of these offsets per hospital was from $125 to $4.5 million. For the sample, the estimated cost to the Medicare program in 1980 was $28 million. The groups of hospitals with the largest mean offsets were those having a larger number of beds, nonprofit or government type of control, a location out of the North Central Region, a location in standard metropolitan statistical areas, and teaching status. Additional analysis incorporated an extension of the test for exclusion from the application of lesser of costs or charges reimbursement to nonprofit and for-profit hospitals.

Disproportionate Share Hospitals and Public General Hospitals: Costs and Case Mix

Funding: Intramural
Project Directors: J. Michael Fitzmaurice and Kenneth Haber
Division of Reimbursement and Economic Studies

Description: Public general hospitals (PGH's) are often the health care "providers of last resort" for patients who cannot afford to pay for their hospital care and are not covered under Medicaid. Because of this special role, public general hospitals frequently incur costs for services provided to many of their (poor) patients for which they do not receive direct reimbursement. Tax-financed subsidies often come from the State or local governments that have jurisdiction over these hospitals, but the hospitals' patient care costs may not be fully covered by these subsidies. This leads to public hospital expenses being greater than revenues and to reduced access to hospital care for part of the population. In the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), the Congress directed the Secretary, Department of Health and Human Services, to consider the "special needs" of hospitals "that serve a significantly disproportionate number of patients who have low income or are entitled to benefits" under Medicare in the application of the Section 101 total operating expense-per-case limits. In addition to TEFRA, there is also concern about the level of rates that PGH's would face under the Medicare prospective payment system. As part of considering the "special needs" of PGH's, this study will examine the Medicare cost reports of public general hospitals to determine if their costs are higher than the costs of other hospitals with the same characteristics as PGH's, other than public ownership. The Medicare case-mix indices of these hospitals and the number of exceptionally long-stay cases will also be examined to see if there is any evidence that PGH patients have measurably higher case complexities.

Status: The data base for this study is the 1980 Hospital Medicare Cost Report File, the 1980 Medicare Case-Mix Index File, and the 1981 Office of Civil Rights Hospitals Survey. These files have been linked, edited, and expanded to include the 1981 hospital cost and case-mix data. This study is expected to be completed in Spring 1985.

Analysis of Medicare Routine Costs Under Alternative Assumptions

Funding: Intramural
Project Director: J. Michael Fitzmaurice
Division of Reimbursement and Economic Studies

Description: This project grew out of a request from the Bureau of Eligibility, Reimbursement, and Coverage, Health Care Financing Administration, to examine the level of Medicare routine costs per day under alternative assumptions about the counting of labor (and false labor) room days as routine costs days. Additionally, the influence of obstetrical room days and pediatric routine days on the level of routine costs is to be investigated.

Status: This study will use published data from the Commission on Professional and Hospital Activities, Hospital Administrative Services, the American Hospital Association, and information derived from hospital Medicare cost reports. The hypothesis that excluding labor room days from the calculation of routine costs per day will increase the routine costs per day will be investigated. Also examined will be the hypothesis that excluding the costs of obstetrical room days and pediatric routine days from the costs of all other general service routine patient days (they are currently averaged together) will reduce routine costs per day.

Outpatient

Physician and Other Ambulatory Services in Hospitals: Costs and Determinants

Project No.: 18-P-97880/5
Period: April 1981 - September 1984
Funding: $ 348,318
Award: Grant
Grantee: American Hospital Association
840 North Lake Shore Drive
Chicago, Ill. 60611
Project Officer: Benson Dutton
Division of Reimbursement and Economic Studies

Description: This ambulatory care project involved the collection and analysis of a large and significant data set that is the first in a series of recurring surveys of hospital ambulatory care. The analysis provides a context for better understanding of the costs of hospital-based ambulatory care. The data describes costs of services in hospital outpatient departments.

Status: The principal findings from this study are:

- Large hospitals, teaching hospitals, and hospitals in metropolitan areas are more likely to have an organized outpatient program and department that provide a disproportionately large share of hospital outpatient visits.

- Hospital outpatient visits are distributed among a wide variety of physician specialties, but emphasize primary care specialties.

- For outpatient care, 20 percent of hospital revenue comes from the Medicare program and 16 percent comes from the Medicaid program, compared with 14 percent from Medicare, and 15 percent from Medicaid for emergency departments, and 39 percent from Medicare and 10 percent from Medicaid for inpatient care. For both emergency department and outpatient visits, costs tend to be higher in hospitals with larger inpatient volumes; emergency department services exhibit strong economies of scale.

- Hospitals have higher costs if they have a greater proportion of Medicaid patients, are located in a metropolitan area, or are located in an area with high per capita income.

- Hospitals with a medical school affiliation are no more costly than other hospitals, except for Council of Teaching Hospitals members which have costs 15 percent higher than the others.

The final report is available from the National Technical Information Service, accession number PB85-149110.

Comparison of Services in Hospital Outpatient Departments and Physician Offices

Project No.:	500-83-0037
Period:	September 1983 - September 1984
Funding:	$ 37,104
Award:	Contract
Contractor:	Mandex, Inc. 8302D Old Courthouse Road Vienna, Va. 22180
Project Officer:	Benson Dutton Division of Reimbursement and Economic Studies

Description: This study analyzed data developed under a prior study of services that were performed in either physicians' offices or hospital outpatient departments. The study identified the character and scope of physicians' services used by Medicare patients in hospital outpatient settings, and compared the array of laboratory, pathology, and radiology (diagnostic) procedures associated with specific treatment procedures that were provided in an office as opposed to a hospital outpatient setting.

Status: The project has been completed and the final report was submitted May 1984. Conclusions from the study show that the hospital outpatient department services billed to Medicare patients by physicians identified as providing a relatively high frequency of such services, or as having relatively high aggregate charges, are basically emergency room services. These high frequency/high charge physicians appear to be "emergency room" physicians. The final report and an addendum from this project are available from the National Technical Information Service, accession numbers PB83-213736 and PB84-243435, respectively.

Development of an Ambulatory Patient Classification System

Project No.: 18-P-98361/1-02
Period: September 1983 - September 1985
Funding: $ 713,404
Award: Grant
Grantee: Yale University
320 York Street
New Haven, Conn. 06520
Project Officer: John T. Petrie
Division of Reimbursement and Economic Studies

Description: This study will develop an outpatient classification system to define a manageable number of patient categories that have similar patterns of resource use. The classification will take into account the spectrum of resources used to deliver ambulatory care. The unit of analysis will be the patient visit rather than an episode of illness. Clinicians will review the grouping of patients that will be suggested by statistical methods. The classification will apply to items over which physicians have control, that is, diagnostic tests and treatment associated with a given visit. Yale will then evaluate the resolution, constancy, and predictive performance of the ambulatory classification.

Status: Yale has identified the data elements and data bases with which to develop and test the ambulatory visit groups (AVG) model. They have secured some of these data and arranged subcontracts with the Kaiser Foundation for health maintenance organizations data and with the Missouri Health Data Corporation for hospital outpatient data. The researchers have concluded that the AVG system would be more reliable if it were based on diagnosis rather than on the patient's presenting problem or chief complaint. Yale is creating a series of modified diagnosis clusters based on codes from the International Classification of Diseases, 9th Revision, Clinical Modification. Using data from the 1979 National Ambulatory Medical Care Survey, Yale and its physician consultants are now developing clusters for all the major diagnostic categories.

Case Mix and Resource Use in Hospital Emergency Room Settings

Project No.: 18-P-98310/9-02
Period: March 1983 - March 1985
Funding: $ 474,028
Award: Grant
Grantee: University of California
School of Public Health
405 Hilgard Avenue
Los Angeles, Calif. 90024
Project Officer: John T. Petrie
Division of Reimbursement and Economic Studies

Description: The purpose of this study is to develop a patient classification scheme and case-based, cost-control system for hospital emergency room settings. Such a system might provide the Health Care Financing Administration (HCFA) with the foundation for reimbursing hospitals on a case-mix basis for the treatment of emergency room patients. The project will yield a system for integrating clinical and fiscal information, on a visit-specific basis, for hospital emergency rooms.

Status: The investigators have completed the time-motion portion of the project. This entailed measuring the amount of time emergency services personnel spent caring for a sample of patients in four Los Angeles area hospitals (one teaching hospital and three nonteaching hospitals). They also determined the specific variables to be abstracted from medical records from the hospital emergency rooms, developed an abstracting format, and collected and coded the medical record data. Work is now underway to construct the emergency room patient classification system. No preliminary findings are available.

Development of a Case-Mix-Based Reimbursement Method for Hospital Outpatient Departments and Freestanding Clinics

Project No.:	18-P-98300/1-02
Period:	March 1983 - March 1986
Funding:	$ 790,108
Award:	Grant
Grantee:	Brandeis University Florence Heller Graduate School Waltham, Mass. 02139
Project Officer:	John T. Petrie Division of Reimbursement and Economic Studies

Description: The purpose of this grant is to provide accurate case-mix and patient socioeconomic data about visits to hospital outpatient departments (OPD's) and freestanding clinics. The grantee will develop a case-mix-based methodology, similar to the diagnosis-related groups (DRG's), which the Health Care Financing Administration can use for reimbursing hospital OPD's. The project is designed to provide policymakers with information on the special situation of hospital OPD reimbursement, and investigate why the same visit to a hospital OPD can cost twice as much as a visit to a physician in private practice. The case-mix reimbursement system will be used to compare OPD's with each other with respect to medical and social differences in case load, and to reimburse OPD's the same amount for patients of the same type.

Status: Brandeis has collected data and performed preliminary analysis on about 3,000 patient visits from primary care, pediatric, and obstetrics-gynecology neighborhood health centers in Boston. It has concentrated further data collection efforts on hospital oncology clinics and classified this visit data for cancer patients using the Yale ambulatory visit groups (AVG's). In an effort to cooperate with Yale in the refinement of the AVG classification system, Brandeis has analyzed its own data for hospital outpatient departments and neighborhood health clinics using the current AVG computer program.

Incorporating the Cost of Ambulatory Care into Case-Mix-Based Hospital Reimbursement

Project No.:	18-P-98426/3-02
Period:	September 1983 - September 1985
Funding:	$ 210,000
Award:	Grant
Grantee:	Blue Cross of Western Pennsylvania One Smithfield Street Pittsburgh, Pa. 15222
Project Officer:	John T. Petrie Division of Reimbursement and Economic Studies

Description: This project is developing a method for integrating hospital inpatient and outpatient reimbursement mechanisms. Blue Cross is building on work performed under a previous Health Care Financing Administration grant in which it developed a classification of clinically distinct inpatient groups called patient management categories (PMC's). This project will refine the PMC's by constructing a computerized outpatient data base, identifying services that are provided in ambulatory settings, and assigning hospital costs to each service. It will identify patients who are currently hospitalized who can be managed effectively in ambulatory settings. Finally, it will analyze hospital inpatient and outpatient data to form a measure of the costliness of a hospital's patient mix.

Status: The researchers have identified a list of ambulatory procedures that will be reviewed by physicians to confirm that these procedures can be effectively managed in ambulatory settings. They have concluded that it is not possible to derive accurate cost information concerning ambulatory care delivered outside the hospitals in the data base. They have broadened the original focus on the analysis of high-volume, short-stay admissions and physician-specified patient types that do not necessarily require hospitalization. The researchers are now reviewing all patient management categories as candidates for ambulatory management.

New York State Ambulatory Care Reimbursement Project

Project No.: 11-C-98574/2-01
Period: September 1984 - August 1987
Award: Cooperative Agreement
Awardee: New York State Department of Social Services
40 North Pearl Street
Albany, N.Y. 12243
Project Officer: Rose M. Truax
Division of Hospital Experimentation

Description: The New York State Department of Social Services and the Office of Health Systems Management jointly submitted this proposal. The awardee will develop and implement a prospective ambulatory care reimbursement methodology for both freestanding clinics and hospital-based ambulatory care services that is predicated on a uniform cost comparison by a patient-care service classification. The methodology will include adjustments to costs directly dependent on case mix and will also employ norms to ensure efficient production of services. New York feels that the result of this 3-year demonstration will be a greater understanding of the fundamental elements of ambulatory care costs, and, more importantly, the use of an equitable reimbursement policy for pricing ambulatory care in a manner that will promote economical delivery of health care and prudent cost growth.

Status: The awardee spent the first 4 months of the project hiring staff and setting up the organizational structure necessary for conducting the demonstration. A literature search will be completed sometime in January. Data analysis is scheduled to begin in Fall 1985.

Hospital Prospective Payment

National Hospital Rate-Setting Study

Project No.: 500-78-0036
Period: August 1978 - October 1985
Funding: $ 5,544,478
Award: Contract
Contractor: Abt Associates, Inc.
55 Wheeler Street
Cambridge, Mass. 02138
Project Officer: Richard Yaffe
Division of Hospital Experimentation

Description: This is the evaluation of the impact of 15 hospital prospective reimbursement programs from 1970 to 1979. The study focuses on the following eight areas:

- Hospital revenue, expenditures, and financial viability.
- Volume of hospital services.
- Hospital payroll costs and staffing.
- Patient care.
- Hospital capital formation, competition, and industrial structure.
- Hospital organization and administrative behavior.
- Access to hospital services.
- Medicare hospital and nonhospital costs.

In addition, the study will provide updates on program impacts in more recent years (up to 1981) in the areas of revenue and expenditures, volume of services, payroll and staffing, and patient care.

Status: Final reports covering three of the above eight areas are currently available. These reports are available through the National Technical Information Service:

- "The Impact of State Hospital Prospective Reimbursement Programs on Medicare Hospital and Nonhospital Costs," accession number PB84-181544.

- "The Impact of State Hospital Prospective Reimbursement Programs on Hospital Capital Formation, Competition, and Industrial Structure: An Evaluation," accession number PB84-181445.

- "The Impact of Prospective Reimbursement on Hospital Payroll Costs and Staffing," accession number PB84-181403.

Final reports covering the remaining five areas will become available throughout 1985.

Incentive Prospective Payment System for Hospitals Through Fiscal Intermediaries (Massachusetts)

Project No.: 95-P-98199/1-01
Period: September 1982 - September 1986
Award: Grant
Grantee: Massachusetts Hospital Association
5 New England Executive Park
Burlington, Mass. 01803
Project Officer: Diane L. Rogler
Division of Hospital Experimentation

Description: This is a statewide, all-payer, prospective hospital reimbursement project proposed for Medicare by the Massachusetts Hospital Association and for Medicaid by the Massachusetts Department of Public Welfare. The payment methodology is based on a contract (HA-29) which is between the hospitals and Blue Cross of Massachusetts (BCM). Hospital payments, including both inpatient and outpatient, are based on the "maximum allowable cost" methodology which uses the actual fiscal year 1981 base-year costs, adjusted annually for inflation and volume changes. Each year, the amount paid to hospitals by Medicare and Medicaid is reduced by a 2-percent productivity factor. The payment system is administered by Blue Cross of Massachusetts. The Massachusetts Rate-Setting Commission approves each hospital's gross patient-service revenue based on their review of the BCM cost report and provides an oversight function. The rate of increase in Medicare hospital expenditures in Massachusetts is capped at the average rate of increase experienced by Medicare nationwide. If total Medicare hospital costs are less than 1.5 percent below the national average rate of increase, the hospitals will share in half of the savings.

Status: Implementation of the project began October 1, 1982. Currently, charges and payments from Blue Cross, Medicare, and Medicaid are based on the maximum allowable cost methodology with some methodological variations existing for each payer. The demonstration is scheduled to end on September 30, 1985, for most of the hospitals. For the nine hospitals that have a July-June fiscal year, the demonstration is scheduled to end on June 30, 1986. For the first year of the project and fiscal year ending October 1, 1983, total Medicare payments are estimated to have grown 13.35 percent.

Rochester Area Hospitals' Corporation

Project No.: 95-P-97501/2-02
Period: January 1980 - December 1986
Award: Grant
Grantees: State of New York/Rochester Area Hospitals' Corporation
Empire State Plaza Tower Building
Albany, N.Y. 12237
Project Officer: Vic McVicker
Division of Hospital Experimentation

Description: The Rochester Area Hospitals' Corporation Hospital Experimental Payment Program is a test of whether an areawide budget system will be effective in controlling hospital costs in a metropolitan area, and whether local decisionmaking can effectively allocate financial resources between hospitals to cover the cost of new services. This 7-year project, which includes all third-party payers (Medicare, Medicaid, and Blue Cross), was initiated January 1, 1980, and includes nine hospitals in the Rochester area of New York. The Hospital Experimental Payment Program places an upper limit or cap on the total revenue paid to the community's hospitals for all patient care. Each participating hospital's revenue for years is guaranteed at a base level, calculated primarily from the hospital's 1978 costs, trended forward to reflect inflation.

Status: Based on an assessment of the 5 years of operation, HCFA has agreed to extend the current demonstration through December 31, 1986, with an option for a third year. Total Medicare payments under the demonstration (1980-84) increased at an average annual rate of 10.9 percent. This is substantially below the national average Medicare rate of 16.7 percent. Additionally, Medicare payments under the project are estimated to be lower in 1985 than under the national prospective payment system. The extension will incorporate the following objectives:

- The inclusion of capital costs under the community revenue cap.
- The use of replacement cost-accounting procedures for major movable equipment.
- New methods for spreading of community costs, such as charity care and direct medical education.
- The use of case-mix adjusters for measuring changes in inpatient volume.

Finger Lakes Area Hospitals' Corporation

Project No.: 95-P-97877/2-01
Period: January 1981 - December 1985
Award: Grant
Grantee: Finger Lakes Area Hospitals' Corporation
One Franklin Square
Geneva, N.Y. 14456
Project Officer: Vic McVicker
Division of Hospital Experimentation

Description: The Finger Lakes Area Hospitals' Corporation (FLAHC) is a test of whether an areawide budget system will be effective in controlling hospital costs in a rural area, and whether local decisionmaking can effectively allocate financial resources between hospitals to cover the cost of new services. This 5-year project, which includes all third-party payers (Medicare, Medicaid, and Blue Cross), was initiated January 1981, and includes eight hospitals in the rural Finger Lakes area of New York. The FLAHC payment program places an upper limit or cap on the total revenue paid to the community's hospitals for all patient care. Each participating hospital's revenue for 5 years is guaranteed at a base level, calculated primarily from the hospital's 1979 costs, trended forward to reflect inflation. In addition, a 2-percent contingency fund is administered by FLAHC to pay for increased hospital services and new and improved medical technology, and to provide working capital for participating hospitals.

Status: Based on an assessment of the first 3 years of operation, the hospitals and payers agreed to maintain the system for the entire 5-year test. Changes in utilization and cost levels of the FLAHC hospitals during the first year of the project were compared with the corresponding changes for two sets of comparable hospitals, one group located in the Syracuse area and the other in Northeastern New York State. From 1980 to 1981, the inpatient cost per day rose 13.3 percent in FLAHC, compared with 13.5 percent for the Syracuse peer group, and 15.0 percent for the Northeastern peer group. Patient discharges dropped 6.1 percent in the FLAHC area, compared with drops of 1.9 percent for the Syracuse peer group and 1.1 percent for the Northeastern peer group. The most relevant cost measure--total inpatient cost--rose 11.4 percent in FLAHC, compared with 16.6 percent for the Syracuse peer group and 14.5 percent for the Northeastern peer group. Other measures of inpatient utilization and cost performance also showed a beneficial effect. From 1980 to 1982, total Medicare payments in the FLAHC program increased by 31.7 percent (22.4 percent occurred in the first year) compared with an increase of 40 percent nationwide. These payments were not adjusted by the estimated 6-percent increase in payments caused by a change in interim payment methodology. For the last 2 years, reimbursement will be limited to trend plus 2 percent; the payers' cost savings should be increased during this period.

Prospective Reimbursement System Based on Patient Case Mix for New Jersey Hospitals

Project No.: 600-77-0022
Period: December 1976 - December 1984
Funding: $ 4,912,802
Award: Contract
Contractor: New Jersey State Department of Health
CN 360
Trenton, N.J. 08625
Project Officer: Cynthia K. Mason
Division of Hospital Experimentation

Description: The purpose of this demonstration is to test a hospital prospective payment system based on diagnosis-related groups (DRG's). The award of a contract in 1976 to develop the payment methodology was followed by a 4-year Medicare and Medicaid waiver, effective January 1, 1980. The waiver approval included a cap which limits Medicare and Medicaid financial liability under the State program. All general acute-care hospitals were phased into the system over a 3-year period starting in 1980. The system is applicable to all patients and all third-party payers. Although the 467 DRG's used in the New Jersey system are identical to those employed in the Medicare prospective payment system, the New Jersey system differs significantly from the national program. In New Jersey, the rate calculation metholodogy is governed by State legislation and regulations. Additional financial elements such as bad debts and charity care are included; outliers account for almost 40 percent of the hospital inpatient revenue; and outpatient rates as well as inpatient rates are established by the New Jersey Department of Health.

Status: The Medicare and Medicaid waivers approved for the demonstration were to expire on December 31, 1983. Because the regulations for Section 1886(c) of the Social Security Amendments for 1983 have not been published, the demonstration waivers were extended to December 31, 1984. Section 1886(c) provides for the continuation of State hospital payment programs. In the interim, the State formally requested an 1886(c) waiver according to draft guidelines. An 1886(c) waiver for inpatient services for the period January 1, 1985, to December 31, 1987, has been approved. The demonstration waiver for outpatient services has been extended pending further submissions by the State.

Proposal for the Development of a Hospital Reimbursement Methodology for New York State for the 1980's

Project No.:	95-P-98216/2-01
Period:	January 1983 - December 1985
Award:	Grant
Grantee:	State of New York Department of Health Empire State Plaza Tower Building, Room 1043 Albany, N.Y. 12237
Project Officer:	Joe Cramer Division of Hospital Experimentation

Description: This 3-year project is a test of a prospective per diem payment system for all payers in the State. Rates are determined using 1981 costs as the base. Base-year allowable costs are calculated through the use of peer-group comparisons, with ceilings on ancillary costs and a combined routine cost/length-of-stay ceiling. Once allowable costs were determined, rates for 1983 were calculated by inflating the costs by a trend factor. In 1984 and 1985, a "rate-to-rate" methodology is applied. The system provides for the establishment of bad debt and charity-care pools on a regional basis to be supported by the payers.

Status: Several tasks necessary to finalize the implementation of New York prospective hospital reimbursement methodology (NYPHRM) in the 1983 rate year were completed. The 1983 rates were revised to reflect adjustments in trend factors, approved appeals, case-mix updates, and the ratio of charges to charge factors. Other tasks related to the implementation of NYPHRM in 1984 were also completed. This included adjusting the 1984 revenue caps for the 1983 volume adjustment, the 1983 final trend factor and the mid-year 1984 trend factor, and reimbursement for malpractice costs based on payer experience. An interim evaluation of New York State hospitals' rate of growth for Medicare revenues and utilization during the first year of the waiver was performed. The data for the period 1982-1983 indicates a rate of growth of 7.67 percent whereas preliminary data for 1982-1984 indicates an overall growth rate of 6.04 percent over the 2 years. The recapture plan required by the Medicare waiver was submitted and conditionally accepted by the Health Care Financing Administration. Finally, the New York regional office has completed its review of Medicare payments under NYPHRM to assure compliance with the waiver terms and conditions and is soliciting comments on its draft report.

Prospective Payment System for Acute and Chronic Care Hospitals in Maryland

Project No.: 500-80-0044
Period: June 1980 - June 1984
Funding: $ 2,037,563
Award: Contract
Contractor: State of Maryland Health Services Cost Review Commission
201 West Preston Street
Baltimore, Md. 21201
Project Officer: Thomas A. Noplock
Division of Hospital Experimentation

Description: This project is testing the long-term effects of an all-payer, statewide hospital prospective payment system in Maryland. The Maryland Project uses a public utility commission's approach to hospital rate regulation. The Maryland Health Services Cost Review Commission (HSCRC) established hospital rates and then adjusted them for such items as inflation, volume changes, and pass-through costs. Currently, Maryland employs three separate systems: a detailed budget review system for individual hospitals; an automatic annual inflation adjustment for individual hospitals without a total budget review; and a payment system based on diagnosis, the Guaranteed Inpatient Revenue System.

Status: The present Medicare and Medicaid demonstration waivers have been extended under the authority of Section 402 of the Social Security Amendments of 1967 until the regulations are promulgated for Section 1886(c) and the State's system has been considered under this new Medicare program waiver authority. The HSCRC is currently running a prospective payment system (PPS) model to project what Medicare payments in Maryland would be under PPS. The results of the study are expected in early 1985.

Diagnosis-Related Groups and Nursing Resources

Project No.: 15-C-98500/1-01
Period: July 1984 - July 1986
Funding: $ 427,910
Award: Cooperative Agreement
Awardee: Yale University
School of Organization and Management
320 York Street
New Haven, Conn. 06520
Project Officer: Patricia Willis
Division of Reimbursement and Economic Studies

Description: This congressionally mandated study (Public Law 98-21) investigates the development of a diagnosis-related group (DRG)-specific nursing intensity measure for application in the management, planning, and budgeting of hospital nursing resources. This measure will be related to a commonly used nurse staffing algorithm. It will be compatible with cost-accounting systems so that it may be used to refine the contribution of nursing costs to the total costs of patient care. Also, it is intended that it should be empirically derived for each DRG, clinically meaningful to nurses, and it should possess known statistical characteristics at the DRG level. The developers propose to examine Grace-Reynolds Application and Study of Peto (GRASP) nursing intensity measures for five Massachusetts Health Data Consortium hospitals and billed nursing costs (i.e., charges) at St. Luke's Hospital in Phoenix, Arizona. These data will be analyzed by DRG to develop statistics for the GRASP points and charges, "cost" the nursing service for each DRG at one site, and analyze the intragroup variance within DRG's. Finally, the researchers will assess the extent to which nursing resource measures capture differences in severity of illness within DRG's.

Status: The research team has conducted negotiations to acquire the proposed data bases and has tested preliminary analyses of this data. The final results of this study will be available late Summer 1986 and they are expected to contribute significantly to the Office of Research and Demonstrations research agenda on severity of illness and other modifications of the DRG system.

Children's Hospital Case-Mix Classification System Project

Project No.: 95-C-98570/3-01
Period: July 1984 - July 1985
Funding: $ 395,000
Award: Cooperative Agreement
Awardee: National Association of Children's Hospitals and Related Institutions
325 First Street
Alexandria, Va. 22314
Project Officer: John C. Langenbrunner
Division of Reimbursement and Economic Studies

Description: This study has three objectives. The first objective of the project is to evaluate the extent to which diagnosis-related groups (DRG's) define homogenous groupings of pediatric patients across different hospital settings, including Children's Hospitals. The second objective is to evaluate the extent to which other case-mix classification systems define homogenous groupings of pediatric patients across different hospital settings, including Children's Hospitals, and based on the strengths and weaknesses of the various systems, to develop a refined pediatric classification system. Alternative classification systems to be considered are disease staging, severity of illness, patient management categories, and pediatric diagnostic system--a system under initial development by five California Children's Hospitals. The third objective is to verify or modify the refined pediatric classification system based on detailed cost information, and to evaluate the manner and extent to which the refined pediatric classification system can best be incorporated into prospective payment for pediatric discharges.

Status: This study was awarded because of the Health Care Financing Administration's interest in pediatric case-mix classification issues in the policy context of the new prospective payment system. The analytic results of this study are scheduled for delivery at the end of the project period. The topic of including Children's Hospitals into the current DRG's will be part of the Annual Report to Congress for December 1985 (mandated by Public Law 98-21) on the prospective payment system.

Selected Analyses of the Prospective Payment System's Impact on Hospitals' Behavior

Project No.: 95-C-98606/3-01
Period: July 1984 - January 1987
Funding: $ 480,423
Award: Cooperative Agreement
Awardee: The Urban Institute
2100 M Street, N.W.
Washington, D.C. 20037
Project Officer: Stuart Guterman
Division of Reimbursement and Economic Studies

Description: This project is congressionally mandated under the Social Security Amendments of 1983 (Public Law 98-21). It will analyze the impact of the Medicare hospital prospective payment system (PPS) on three types of hospital behavior: the provision of services to Medicare beneficiaries by hospital outpatient departments; the discharge of Medicare beneficiaries to and provision of long-term care and home health services; and changes in hospitals' corporate structure and internal organization. The analysis is to be based primarily on data from two hospital surveys conducted by the Urban Institute (UI) and the American Hospital Association (AHA). One survey on hospital revenue and expenses in 1980 and 1982 has been completed. The other survey, to be conducted, is on hospitals' financial experience, the provision of hospital outpatient services and long-term care, and hospital organization in 1984 and 1985.

Status: The new UI/AHA survey is being prepared, and data from the previous survey are being analyzed. An analysis plan has been prepared for comparing the outcome under PPS with the projected outcome under the provisions of the Medicare payment system in effect prior to PPS.

Impact of the Prospective Payment System on the Quality of Inpatient Care

Project No.: 15-C-98663/5-01
Period: September 1984 - September 1988
Funding: $ 145,261
Award: Cooperative Agreement
Awardee: The Commission of Professional and Hospital Activities
1968 Green Road
P. O. Box 1809
Ann Arbor, Mich. 48106
Project Officer: Stuart Guterman
Division of Reimbursement and Economic Studies

Description: This project is congressionally mandated by Public Law 98-21. It will evaluate the effect of the Medicare hospital prospective payment system on the quality of inpatient care received by Medicare patients, by examining several indicators of hospital performance. This examination is to be based primarily on data from the Professional Activity Study maintained by the Commission on Professional and Hospital Activity (CPHA), supplemented by data from several other sources maintained by CPHA.

Status: A detailed research plan is being prepared, and work is beginning on the compilation of the research file that will provide the basis for the empirical study. On completion of these tasks, an initial analysis of the data is to be accomplished.

Severity of Illness and Diagnosis-Related Groups in Selected Cancers

Project No.: 15-C-98678/4-01
Period: September 1984 - September 1987
Funding: $ 214,010
Award: Cooperative Agreement
Awardee: University of Miami
School of Medicine
Comprehensive Cancer Center for the State of Florida
P.O. Box 016960, D8-4
Miami, Fla. 33101
Project Officer: John C. Langenbrunner
Division of Reimbursement and Economic Studies

Description: This project will utilize existing data bases to evaluate the relationship between the intensity of disease and the cost of treating the disease for five common types of cancer--colon and rectum, lung, breast, cervix, and prostate. These five types of cancer represent more than 50 percent of new cancer cases. The project will utilize a staging algorithm developed by the American Joint Committee on Cancer as an adjunct to the current diagnosis-related group (DRG) system for the five types of cancer. New diagnosis categories will be developed that may explain a significantly greater proportion of the variation in resource consumption for treating the given types of cancer than the current DRG system.

Status: This study was awarded because of the Health Care Financing Administration's interest in DRG refinement issues, as well as its interest in policy development regarding hospitals that may attract more complex, sicker patients. The project will be composed of three phases during the next 3 years. During the first phase, criteria for case inclusion and data processing procedures will be finalized and the data set will be established. For the second phase, these data will be analyzed and a set of DRG's using updated patient information will be used to validate the categories. The last phase will involve the testing (and possible modification) of data from several hospitals in the Miami, Fla., area.

Prospective Payment in Rehabilitation Hospitals and Programs

Project No.:	15-C-98705/5-01
Period:	September 1984 - September 1985
Funding:	$ 700,000
Award:	Cooperative Agreement
Awardee:	Medical College of Wisconsin/Rand Corporation 1000 N. 92nd Street, Room 2166 Milwaukee, Wis. 53226
Project Officer:	John C. Langenbrunner Division of Reimbursement and Economic Studies

Description: A cooperative agreement was awarded, effective October 1984, to the Medical College of Wisconsin (MCW) to obtain rehabilitation patient-record and cost data from approximately 8,000 medical charts at 100 rehabilitation hospitals and units across the Nation. The Rand/University of California, Los Angeles, Health Financing Policy Research Center will design the MCW data collection project and conduct the analysis required to investigate the feasibility of a case-mix classification system for Medicare reimbursement of medical rehabilitation hospitals.

Status: Section 603 of Public Law 98-21, Social Security Amendments of 1983, calls for studies incorporating exempt hospitals (such as rehabilitation hospitals) into the Medicare prospective payment system (PPS) by December 31, 1985. The project will provide findings that will assist the Health Care Financing Administration in considering a PPS for rehabilitation hospitals within this time limit.

Learning From and Improving Diagnosis-Related Groups for End-Stage Renal Disease Patients

Project No.:	14-C-98596/3-01
Period:	September 1984 - August 1986
Funding:	$ 187,500
Award:	Cooperative Agreement
Awardee:	The Urban Institute/Health Policy Center 2100 M Street, NW. Washington, D.C. 20037
Project Officer:	Henry Krakauer Division of Beneficiary Studies

Description: The introduction of prospective payment by diagnosis-related groups (DRG's) has drastically altered the incentives in medical care. The purpose of this project is to study the responses of providers at the level of individual patients and diagnoses in end-stage renal disease, an area on which abundant data are available. Specific issues to be addressed include the possiblity of selection of diagnoses to maximize reimbursement, alteration of discharge and admission patterns and other forms of cost-shifting, and the selection of patients for admission. Specifically, patients will be characterized in terms of major demographic and prognostic factors, including measures of severity of illness. Patterns of diagnostic categorization, admission patterns, and treatment costs will be compared for homogenous groups before and after the prospective payment system. This study should give insights into how DRG's might be improved to assure more cost-effective delivery of care.

Status: The study is in its initial stages. Discussions have been held with consultants and the Health Care Financing Administration project staff to define in detail the objectives and the procedures to be followed.

Nonintrusive Outcome Measures: Identification and Validation

Project No.:	15-C-98684/9-01
Period:	September 1984 - September 1987
Funding:	$ 860,679
Award:	Cooperative Agreement
Awardee:	The Rand Corporation 1700 Main Street Santa Monica, Calif. 90406
Project Officer	Sherry A. Terrell Division of Reimbursement and Economic Studies

Description: The main objective of this project is to develop nonintrusive measures to detemine the impact of selected changes in the health care sector, particularly prospective payment and diagnosis-related group (DRG) methodology, on the quality of medical care. A specific goal is to identify short-stay hospital care that may be less than adequate. In addition, diagnoses, procedures, or DRG's that appear to be associated with lower levels of care will be identified. A set of nonintrusive outcome indicators for quality care review is proposed.

Status: The first stage of the study design has been implemented. Specification of data from the Medicare statistical system has been completed, and this secondary data is under development. In addition, development has begun on chart review protocols for validation of the secondary data that is in the administrative record data. Valid quality measures for the outcome data are obtained through primary chart and medical record review of selected conditions.

Response of Massachusetts Acute-Care Hospitals to the Massachusetts Cost-Containment Act

Project No.: 15-C-98635/1-01
Period: December 1984 - November 1987
Funding: $ 590,395
Award: Cooperative Agreement
Awardee: Tufts University
School of Medicine
136 Harrison Avenue
Boston, Mass. 02111
Project Officer: Patricia Willis
Division of Reimbursement and Economic Studies

Description: This study will assess the impact of the Massachusetts Cost-Containment Act (Chapter 372 of the General Laws) on the behavior of acute-care hospitals. In particular, the study will examine the effectiveness of the strategies devised by the hospitals to circumvent the cost restrictions, the internal adjustment processes (e.g., reductions in personnel, laboratories, and other activities) adopted to cope with the level of resource constraints imposed on the hospitals, and the responses to the constraints of hospital managers and professionals and the public that are recorded in the media. The study will contrast the impact of the Massachusetts regulatory environment to other State health cost environments that are less regulated. The study may investigate other strategies for health care cost containment, for example, the sources of wide geographical differences in costs among similar hospitals.

Status: This study was recently awarded, and is presently being revised to reflect the Office of Research and Demonstrations' (ORD) research priorities and data availability. This study may present results to assist ORD in evaluating the impact of State systems on hospital payment, a report that is mandated by the Congress (Public Law 98-21) for inclusion in the Annual Impact Report for 1986.

Annual Reports to Congress on the Impact of the Medicare Hospital Prospective Payment System

Funding: Intramural
Project Director: Stuart Guterman
Division of Reimbursement and Economic Studies

Description: Section 603 of Public Law 98-21 requires the Secretary of Health and Human Services to study and report annually to Congress on the impact of the Medicare prospective payment system (PPS) for hospitals. These Reports to Congress, beginning in 1984 and ending in 1987, are to focus on the impact of PPS on classes of hospitals, beneficiaries, and other payers for inpatient hospital services, and, in particular, on the impact of computing diagnosis-related groups prospective payment rates by census division, rather than exclusively on a nationwide basis.

Status: The draft of the first annual report includes a discussion of the background of the Medicare hospital prospective payment system (PPS), an outline of the objectives of this multi-year evaluation effort, and a presentation of preliminary findings from the first year of the PPS. The second of four mandated annual reports is expected by the end of 1985, and will further analyze some of the findings from the first year of PPS, as well as presenting data from the second year of the new payment system. In addition, several additional topics (as discussed in the following project write-up) are to be addressed in the 1985 report, according to congressional mandate. The remaining annual reports are to continue the analysis begun in the first two reports and address the additional issues specified in the congressional mandate.

Studies of Issues to be Included in the 1985 Annual Report to Congress

Funding: Intramural

Description: Section 603 of Public Law 98-21 requires the Secretary of Health and Human Services to include the results of the following studies in the Annual Report to Congress for 1985:

- The feasibility and impact of eliminating or phasing out separate urban and rural prospective payment rates for diagnosis-related groups (DRG's).
- Whether and how hospitals not currently paid according to the prospective payment system (PPS) methodology under Medicare can be paid on a prospective payment basis.
- The appropriateness of the PPS methodology for compensating hospitals for the additional expenses of outlier cases, and the advisability and feasibility of applying severity of illness, intensity of care, or other modifications to prospective payment rates for DRG's.
- The feasibility and desirability of applying the PPS methodology to payment by all payers for inpatient hospital services.
- The impact of PPS on hospital admissions, and the feasibility of making a volume adjustment in the prospective payment rates for DRG's or requiring preadmission certification to minimize the incentive to increase admissions.

Topic: Urban/Rural Rates
Project Director: Philip Cotterill
Division of Reimbursement and Economic Studies

Status: Several areas related to this issue are to be investigated under the cooperative agreement with the Brandeis University Health Policy Research Consortium. It is also anticipated that several intramural studies will be conducted in relation to specific congressional concerns.

Topic: Exempted Hospitals and Units
Project Directors: John C. Langenbrunner, Patricia Willis, and Stephen Jencks
Division of Reimbursement and Economic Studies

Status: The National Institute of Mental Health, with funds transferred from the Health Care Financing Administration (HCFA), awarded a contract during the third quarter of fiscal year 1984 for the investigation and development of alternative patient classification systems for psychiatric and alcohol and drug abuse hospitals and units. Additional studies on this topic, not funded by HCFA, are to be monitored. The National Association of Children's Hospitals and Related Institutions was awarded a cooperative agreement by HCFA during the fourth quarter of 1984 for the investigation and development of alternative pediatric classification systems. The Medical College of Wisconsin (MCW) was awarded a cooperative agreement by HCFA at the beginning of the first quarter of 1985 for the collection of patient record data in rehabilitation hospitals and units. The Rand Corporation/University of California, Los Angeles, Health Financing Policy Research Center is participating in the design of the MCW project and the development of alternative patient classification systems for rehabilitation facilities.

The Brandeis University Health Policy Research Consortium is investigating the characteristics (e.g., geographical distribution) of long-stay hospitals. The Brandeis Consortium is also providing assistance in the development of a conceptual framework for consideration of the method of inclusion of these hospitals under prospective payment.

Topic: Outlier Payments
Project Philip Cotterill
Director: Division of Reimbursement and Economic Studies

Status: It is anticipated that several intramural studies will be conducted in relation to specific congressional concerns on this issue. The Rand/University of California, Los Angeles, Health Financing Policy Research Center may also assist HCFA's Office of Research in this effort.

Topic: Severity of Illness and Intensity of Care
Project Stephen Jencks and Patricia Willis
Director: Division of Reimbursement and Economic Studies

Status: The Rand/University of California, Los Angeles, Health Financing Policy Research Center is developing several projects that will assess the extent to which inadequacies in the measurement of severity of illness within the DRG system may encourage inequitable payments to hospitals and will investigate the applicability of alternative case-mix measurement systems. Both the Rand/UCLA Center and the Brandeis Consortium are developing multi-year research agenda for improvement of case-mix measurement systems on which to base Medicare payment. One article has been published: "Evaluating and Improving the Measurement of Hospital Case Mix," Health Care Financing Review, 1984 Annual Supplement, HCFA Pub. No. 03194, November 1984. This supplement issue, which addresses the topic of severity of illness in depth, is available for sale from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402, for $4.25.

Topic: Other DRG Modifications
Project Philip Cotterill
Director: Division of Reimbursement and Economic Studies

Status: The recalibration of DRG relative weights is the major modification currently planned. Additional intramural studies are anticipated in response to specific congressional concerns.

Topic: All-Payer Methodology
Project J. Michael Fitzmaurice
Director: Division of Reimbursement and Economic Studies

Status: The Brandeis Consortium is to conduct a comparative study of State rate-setting systems which apply to all payers for inpatient care, and their effects on the costs borne by each type of payer.

Topic: Impact on Admissions
Project Director: Stuart Guterman
Division of Reimbursement and Economic Studies

Status: The Rand/UCLA Center will investigate the detection of excess hospital admissions, and whether the implementation of prospective payment leads to such excess hospital admissions.

Topic: Volume Adjustment
Project Director: Philip Cotterill
Division of Reimbursement and Economic Studies

Status: The Rand/UCLA Center is to conduct a review of approaches to the effect of excess admissions on Medicare payment and the control of excess admissions. Further efforts will depend on the findings on the impact of prospective payment on admissions volume.

Prospective Payment Beneficiary Impact Study

Funding: Intramural
Project Directors: James Lubitz and Paul Eggers
Division of Beneficiary Studies

Description: The analyses in this study area are designed to measure changes in hospitalization as a result of prospective payment that may impact on Medicare beneficiaries. There are four study areas:

- Analyses of discharge rates and average length of stay.
- Changes in discharge status and post discharge mortality and rehospitalizations.
- Changes in mix of services among Medicare beneficiaries.
- Changes in the concentration of selected diagnosis-related groups, diagnoses, and procedures among hospitals.

Status: Baseline data analyses have been performed and are included in the draft 1984 Annual Report to Congress on prospective payment mandated by Public Law 98-21.

Swing Bed

Evaluation of National Rural Swing-Bed Program

Project No.: 500-83-0051
Period: September 1983 - June 1986
Funding: $ 722,248
Award: Contract
Contractor: Center for Health Services Research
University of Colorado Health Sciences Center
4200 East Ninth Avenue
Denver, Colo. 80262
Project Officer: Herbert A. Silverman
Division of Program Studies

Description: This project is congressionally mandated by the Omnibus Reconciliation Act of 1980 (Public Law 96-499). The legislation permits hospitals with fewer than 50 beds that are located in rural areas with a shortage of long-term care beds to "swing" their beds between acute and long-term care as needed. The evaluation will assess the impact on:

- Access to long-term care beds in rural areas.
- Quality of long-term care in hospitals.
- Cost of services in swing-bed hospitals.
- Program-wide costs.
- Administrative costs to administer and monitor the program.

Based on the findings and recommendations, Congress will decide whether to continue the program or extend it to larger hospitals.

Status: Clearance has been received from the Executive Office of Management and Budget for the proposed design and questionnaires. The project is currently in the midst of primary and secondary data acquisition and processing which will be completed in late 1985. A final report with recommendations is expected in mid-1986.

Measuring the Cost of Case Mix Using Patient Management Algorithms

Project No.:	18-P-97063/3-05
Period:	September 1978 - July 1984
Funding:	$ 1,166,846
Award:	Grant
Grantee:	Blue Cross of Western Pennsylvania One Smithfield Street Pittsburgh, Pa. 15222
Project Officer:	John T. Petrie Division of Reimbursement and Economic Studies

Description: This project developed a patient classification system that reflects the diverse hospital resources required to manage clinically distinct patient types. There were two major objectives: to define the array of hospital products or patient types treated by hospitals and to identify the costs of producing these products.

Status: The researchers have met these objectives by completing two distinct phases in the process of measuring case mix: identification of approximately 750 clinically homogeneous patient categories, called patient management categories (PMC's), and development of relative cost weights for each PMC based on the services that a panel of clinicians believed typical patients should receive. Two computer programs have been developed. One classifies hospital cases into PMC's and the other assigns resource requirement weights to the PMC's. The researchers are currently working to complete a three-volume final report expected in Spring 1985. The final report will detail the development of the PMC's and document the PMC software.

Diagnosis-Related Groups Refinement for Nursing Care

Project No.: 15-C-98421/7-02
Period: August 1983 - March 1985
Funding: $ 369,650
Award: Cooperative Agreement
Awardee: American Nurses Association, Inc.
2420 Pershing Road
Kansas City, Mo. 64108
Project Officer: Patricia Willis
Division of Reimbursement and Economic Studies

Description: This congressionally mandated study (Public Law 98-21), will investigate the relative structure of hospital nursing staff resources across 20 high-volume diagnosis-related groups (DRG's) in two Milwaukee area hospitals. The data will include discharge and cost information for all discharges during the period April 1- September 30, 1984. Additionally, the data will include daily measures of Medicus points indicating nursing staff requirements and "nursing diagnosis" items describing patient-care requirements. These data will be analyzed to compare the relative distribution of nursing resources as measured by the Medicus instrument with the relative weights of the current DRG system. The study will also attempt to relate statistically the Medicus measure, which has been reliably correlated to nursing resource intensity, and the nursing diagnosis items--if these items can be summarized meaningfully in a hospital "stay" measure. The final report will evaluate the policy implications of the findings for the allocation of hospital nursing resources in the context of the new prospective payment system (PPS) for Medicare.

Status: This study was awarded because of the Health Care Financing Administration's interest in nursing resource issues in the policy context of the new PPS. The findings will represent a pilot effort to assess the extent to which the current DRG classification system equitably distributes Medicare reimbursement for nursing resource requirements. A final report is due by April 1985.

Severity of Illness Within Diagnosis-Related Groups

Project No.: 18-P-98378/1-01
Period: October 1983 - November 1984
Funding: $ 87,711
Award: Grant
Grantee: The Johns Hopkins University School
of Hygiene and Public Health
Charles and 34th Streets
Baltimore, Md. 21218
Project Officer: Patricia Willis
Division of Reimbursement and Economic Studies

Description: This study will examine the variability within diagnosis-related groups (DRG's) that can be accounted for by the Severity of Illness Index developed over the last several years. Investigation will be made of the extent to which the severity score--a ranking of 1, 2, 3, or 4--and 3 levels of operating room procedures--none, minor, or major--explain the variability of costs within DRG's. Reduction in variance, coefficient of variation, F-test, and linear regression methodologies will be applied by using patient-level data as the unit of observation. The data include discharge abstract and cost information for patients in 31 hospitals--largely teaching hospitals in which data has been collected for varying periods. Data will be analyzed for a single, large hospital and across all hospitals, which will require the development of hospital-specific cost/charge ratios and wage differentials. The study will assess the impact on hospital revenues of a reimbursement scheme based on the DRG and severity case-mix classification systems, respectively.

Status: The grant was awarded to explore the efficacy of the severity measure for variance reduction within the DRG system. At the same time, development of more replicable scoring procedures will be done. The analytic results of this study are scheduled for delivery at the end of the project period. A draft final report is being reviewed by an expert panel. The topic of severity adjustments to the current DRG system will be included in the Annual Report to Congress for December 1985 on the prospective payment system as mandated by Public Law 98-21.

Capital

Medicare-Medicaid Payment Policies and Capital Formation

Project No.: 18-C-98267/1-01
Period: April 1983 - July 1985
Funding: $ 274,805
Award: Cooperative Agreement
Awardee: Center for Health Economics Research
822 Boylston Street, Suite 104
Chestnut Hill, Mass. 02167
Project Officer: Joel Bobula
Division of Reimbursement and Economic Studies

Description: The objective of this project is to provide policymakers with new information on the effects of Medicare and Medicaid payment policies on hospital capital formation, past and future. First, the project will analyze the combined, overall effect of Medicare and Medicaid payment policies so that a policy can be designed that results in adequate, but not excessive, hospital investment in plant and equipment. Second, the project will analyze the impact of payment policies on hospital decisions to implement cost-saving or cost-inducing technologies. To complement these analyses, the following issues will be studied empirically:

- The effect of hospital dependence on Medicare and Medicaid revenues on hospital financial status and capital formation.
- The effects of alternative payment policies, especially prospective payment, on capital formation.
- The relationships between Medicare and Medicaid payment policies, hospital competition, and capital formation.
- The effects of public payment policies on hospital closures and mergers.
- The adoption of cost-saving or cost-inducing technology.

Data to be used in the project includes the Abt National Rate-Setting Medicare Cost Report file of 2,500 hospitals covering the period 1970-79. Parallel analyses will be conducted using American Hospital Association data for the period 1974-82. These files are operational currently. Some additional data will be collected for small pilot studies.

Status: The grantee has prepared two discussion papers:

- "Treatment of Captial Costs in Four Medicare-Waivered States: Maryland, New Jersey, New York, and Massachusetts."
- "Capital Cost Reimbursement Options."

An interim report on the first year's activities under the grant was received in August 1984. A final report is expected in mid-1985.

Data Development and Analyses

Data for Hospital Cost Monitoring and Analysis of Hospital Costs

Project No.:	500-80-0066
Period:	September 1980 - September 1985
Funding:	$ 931,800
Award:	Contract
Contractor:	American Hospital Association 840 North Lake Shore Drive Chicago, Ill. 60611
Project Officer:	J. Michael Fitzmaurice Division of Reimbursement and Economic Studies

Description: This project obtains survey data from a set of hospitals that are surveyed monthly about their costs and activities. This serves as a prime source of outside data on the performance of hospitals and is used in Health Care Financing Administration (HCFA) analyses, research, and publications.

Status: To date, HCFA has received monthly "National Hospital Panel Survey Reports" and monthly "Community Hospital Statistics" through June 1984. The data are available in both hard copy and computer tape format.

Financially Troubled Hospitals

Metropolitan Comprehensive Care Program: A Health Systems Organization Demonstration

Project No.: 11-P-97805/2-05
Period: September 1980 - September 1985
Award: Grant
Grantee: New York State Department of Social Services
40 North Pearl Street
Albany, N.Y. 12243
Project Officer: Rose M. Truax
Division of Hospital Experimentation

Description: The demonstration is designed to test a new financing and health care role for municipal hospitals. The demonstration is specifically targeted for the medically indigent and all other members of the East Harlem community. During the 5-year demonstration, which is based at Metropolitan Hospital, coverage will be provided to a maximum of 17,100 poor and near-poor residents of the community who are ineligible for Medicaid coverage under existing Federal/State regulations. The five critical components of the demonstration are:

- The case-management system.
- The reorganization of the hospital-management and financial systems.
- The introduction of the Citycaid program.
- Improved screening for Medicaid, Citycaid, and other third-party insurance.
- The establishment of a State-qualified health maintenance organization (HMO).

Status: The focus of the first 3 years' activities was establishing administrative mechanisms and implementing organizational changes to support a case-management approach to medical care for an enrolled population. The fourth year focused on the planning and development of an HMO. The HMO application has been submitted to the State for approval, but approval is not expected before Spring 1985. Enrollment levels have not been growing at the expected rate. As of June 30, 1984, there was a total of 4,696 enrollees in the project, of which 3,123 were Citycaid and 1,573 were Medicaid. The project will end September 28, 1985. A final report is due in December 1985.

Strategies to Improve the Financial Viability of the Urban Hospital

Project No.: 11-P-97866/4-04
Period: January 1981 - September 1984
Award: Grant
Grantee: Florida Department of Health and Rehabilitative Services
1317 Winewood Boulevard
Tallahassee, Fla. 32301
Project Officer: Rose M. Truax
Division of Hospital Experimentation

Description: This 4-year demonstration project will test the feasibility of covering a medically needy population in Florida in a capitated primary care system. Enrollees will lock themselves into care at an urban hospital and its primary care center. The services provided are limited to inpatient, outpatient, physician services, and pharmacy. The approach will demonstrate that:

- Financial viability can be achieved by the use of new "strategies" in the provision of patient care and methods of reimbursement.

- The hospital can serve as an effective case manager, reducing costs and improving health outcomes.

Status: The project became operational October 1, 1981, with the opening of a new primary care center at the University Hospital of Jacksonville. As of July 1, 1983, there were 15,988 enrollees at the center--6,000 newly eligibles, 4,048 currently eligible Medicaid recipients, 1,440 Medicare recipients, 1,460 partial pay (self pay), and 3,040 charity care. During the first quarter of the fourth and final year of the project, recruitment of the "newly eligible" population has been slow. These individuals were to replace enrollees found to be ineligible at the time redeterminations of eligibility were done. Enrollment in the project as of January 1984 was 4,313 newly eligibles and 5,919 currently eligible Medicaid recipients, or a reduction of 1,687 in the newly eligible category. The enrollment figures have remained fairly stable during 1984. As of June 1, 1984, there were 4,694 newly eligibles and 5,943 currently eligible Medicaid recipients. The project ended October 1, 1984. However, the grantee was given a no-cost, 3-month extension to analyze project data and write the final report. The final report is expected in June 1985.

A Proposal to Relieve Financial Distress at a Congested Urban Medical Center

Project No.: 11-P-97817/9-04
Period: January 1981 - January 1985
Award: Grant
Grantee: California Department of Health Services
714-744 P Street
Sacramento, Calif. 95814
Project Officer: Rose M. Truax
Division of Hospital Experimentation

Description: This 4-year demonstration project tests the cost effectiveness of a county health maintenance system with capitated reimbursement for the medically indigent population served at the Los Angeles County/University of Southern California Medical Center and a community health care center. The approach will demonstrate that:

- Financial viability can be achieved by the use of new "strategies" in the provision of patient care and methods of reimbursement.
- The hospital can serve as an effective case manager, reducing costs and improving health outcomes.

Status: The first 2 years of this project was a developmental phase. The project became operational February 1, 1983. There were 2,095 enrollees in the project as of October 1, 1984, 1,300 newly eligibles, and 795 currently eligible Medicaid recipients. The project was expanded to include a second community health center in January 1984. This project is scheduled to end on January 15, 1985. A final report is expected in Fall 1985.

Skilled Nursing Facility Prospective Payment

Alternative Nursing Home Reimbursement Systems for Medicare

Project No.: 16-C-98274/3-01
Period: January 1983 - March 1985
Funding: $ 280,601
Award: Cooperative Agreement
Awardee: The Urban Institute
2100 M Street, N.W.
Washington, D.C. 20037
Project Officer: Joel Bobula
Division of Reimbursement and Economic Studies

Description: This study analyzed alternative approaches to prospective payment for Medicare skilled nursing facilities (SNF's) and investigated administrative factors that affect the efficiency of patient-related, rate-payment systems. The data used in this study were derived from 1980 Medicare cost reports and the Medicare/Medicaid Automated Certification System. The merging of these files produced a data base which included 3,492 of the 4,900 Medicare certified SNF's filing cost reports in 1980. These sample facilities accounted for roughly seven-eighths of all Medicare patient days provided that year.

Status: An interim report was received in April 1984. Analysis of the Medicare cost reports of skilled nursing facilities has shown that several proxy measures of case mix are important factors in explaining differences in SNF per diem costs. Higher costs are associated with a greater percentage of Medicare days, a higher number of admissions per bed, and greater nursing hours per inpatient day. These factors may indicate facilities with a greater orientation towards the short-term, rehabilitative Medicare patient. They only partially explain the higher costs observed for hospital-based, as opposed to freestanding, SNF's. A final report is expected in mid-1985.

New York State Capitation Payment System for Long-Term Care

Project No.: 11-P-98194/2-02
Period: March 1982 - June 1984
Funding: $ 659,632
Award: Grant
Grantee: New York State Department of Social Services
40 North Pearl Street
Albany, N.Y. 12243
Project Officer: Dennis M. Nugent
Division of Long-Term Care Experimentation

Description: The purpose of this demonstration was to reduce the backup of hospitalized Medicaid patients who could not be discharged because of the limited availability of nursing home beds. In an effort to control the escalation of hospital expenditures, the Rochester Area Hospitals' Corporation proposed a risk-sharing capitation method of reimbursement which provided positive incentives for appropriate placement.

Status: In May 1984, the State notified the Health Care Financing Administration of its decision not to continue this demonstration. Despite intensive negotiations, agreement could not be reached between the State and the Rochester Area Hospitals' Corporation on important elements of the demonstration, design, and methodology. Therefore, the project was ended on June 15, 1984.

Longitudinal Study of the Impact of Prospective Reimbursement Under Medicaid on Nursing Home Care in Maine

Project No.: 18-C-98307/1-02
Period: June 1983 - June 1986
Funding: $ 467,314
Award: Cooperative Agreement
Awardee: University of Southern Maine
Human Services Development Institute
246 Deering Avenue
Portland, Maine 04102
Project Officer: Judith Sangl
Division of Reimbursement and Economic Studies

Description: This project studies the recently implemented nursing home prospective reimbursement system in Maine. The study will provide a longitudinal evaluation of the design and implementation of the system for intermediate care facilities in the State and of the system's effectiveness in achieving the policy goals of containing costs, maintaining or improving quality, and ensuring access to nursing home care by Medicaid recipients. The study consists of three major components:

- An impact analysis of the effects of prospective reimbursement on costs, quality, and access.
- A case study of the politics of the implementation of prospective reimbursement.
- An analysis of organizational and management response of nursing home administrators to the changes resulting from prospective reimbursement.

The hypotheses of the study are closely tied to the objectives of recently passed reimbursement legislation which includes incentives for maintaining and increasing Medicaid patient load. The awardee will try to measure immediate versus long-term effects of the new system on costs to the State.

Status: Major project activities to date are:

- Development of case-mix and quality-of-care measures.
- Collection of historical cost-report data for 3 years prior to implementation of the prospective reimbursement system.
- Survey of nursing home administrations and directors of nursing regarding the industry's response to the new reimbursement system.
- Collection of nursing home licensure and certification survey data for measures of quality of care.
- Start of collection of patient-assessment data for the case-mix measures.

Two reports have been prepared:

- "The Development and Implementation of Maine's Nursing Home Prospective Payment System."
- "Management Responses to Maine's Nursing Home Prospective Payment System."

New York State Case-Mix, Prospective Reimbursement System for Long-Term Care

Project No.:	11-C-98325/2-01
Period:	August 1983 - August 1986
Funding:	$ 416,012
Award:	Cooperative Agreement
Awardee:	New York State Department of Social Services 40 North Pearl Street Albany, N.Y. 12243
Project Officer:	Elizabeth S. Cornelius Division of Long-Term Care Experimentation

Description: The New York State Department of Social Services was awarded a Section 1115 grant, effective August 7, 1983, to develop, test, and refine a long-term care prospective reimbursement system based on clusters of patient characteristics. This is a 3-year cooperative agreement being conducted by the New York State Department of Health and Rensselaer Polytechnic Institute. The system will build on the results of research conducted at Yale University which developed clusters of patients in relation to staff resources used (Resource Utilization Groups or RUG's). The purpose of the project is to promote efficiency by associating payment levels with patient characteristics that indicate the amount of actual resources used by patients.

Status: This project is in the developmental stage. The State has hired the project staff and has selected a national and a State advisory group. These groups have met and developed a timetable for the project. The first phase of data collection has been completed on 3,800 patients in 51 institutions. During the second year, the data have been analyzed and 16 clusters have been developed. Five major hierarchy groups, which are based on the clinical problems of the patients, are used in developing the clusters. Each group is split based on a sum of activities of daily living (ADL) dependencies. Three ADL's (eating, transferring, and toileting) are used in developing the scale. The next task during the second year will be designing the new case-mix reimbursement methodology. In addition, a patient assessment audit process will be developed and tested. The RUG's have been compared with three other case-mix measures and researchers have reported 93-percent agreement between the data sets.

Resource Utilization Groups: Validation and Refinement of a Case-Mix System for Long-Term Care Reimbursement

Project No.: 18-C-98499/1-01
Period: July 1984 - October 1985
Funding: $ 248,924
Award: Cooperative Agreement
Awardee: Yale University
School of Organization and Management
New Haven, Conn. 06520
Project Officer: Marni Hall
Division of Reimbursement and Economic Studies

Description: This project continues Yale's prior work (also supported by the Health Care Financing Administration), which developed the resource utilization groups (RUG's) classification system for residents of long-term care facilities. This project will refine the original RUG's and correct deficiencies, e.g., the inclusion of some process variables, instead of just clinical variables, and reliance on subjective estimates of staff time. Unlike the prior project, it will take into account the rate at which patients' conditions change.

Status: This project has begun work that will derive an appropriate measure of resource use for the development of the new RUG system. This measure, called a "unit of service," will reflect the relative service requirements of different types of patients within a facility, while also allowing the pooling of observations from various facilities in spite of inter-facility differences. This project also critiqued a number of long-term care data bases and selected some that appear to be most appropriate for validation of the new RUG's.

Case-Mix Measure for Long-Term Care Medicare Patients

Project No.: 18-C-98581/2-01
Period: July 1984 - October 1985
Funding: $ 253,199
Award: Cooperative Agreement
Awardee: Rensselaer Polytechnic Institute
School of Management
Troy, N.Y. 12181
Project Officer: Marni Hall
Division of Reimbursement and Economic Studies

Description: This project is a continuation of work begun under a Health Care Financing Administration-sponsored Yale University grant to develop resource utilization groups (RUG's) for long-term care patients. The RUG's contain individuals with similar resource consumption. The original set of RUG's was developed by using mostly Medicaid patients. This project will develop RUG's for Medicare skilled nursing facility patients. The role of diagnostic variables and service/treatment variables as part of the classification system will be evaluated. This project will also develop relative case-mix weights for each classification.

Status: This project has developed the patient-assessment instrument to be used in this study, has been developing procedures for collection of staff-time data, and is recruiting nursing homes in California, Florida, Illinois, New York, and Pennsylvania to participate in this study.

Texas Long-Term Care Case-Mix Reimbursement Project

Project No.: 11-C-98688/6-01
Period: September 1984 - September 1986
Funding: $ 272,494
Award: Cooperative Agreement
Awardee: Texas Department of Human Resources
701 West 51st Street
Austin, Tex. 78769
Project Officer: Elizabeth S. Cornelius
Division of Long-Term Care Experimentation

Description: The Texas Department of Human Resources was awarded a 2-year cooperative agreement effective September 30, 1984, to develop and test a prospective case-mix reimbursement methodology for long-term care facilities. Case-mix reimbursement involves assessment of patient characteristics associated with various patterns of service needs and reimbursement at a rate appropriate to that need. The case-mix reimbursement methodology will reflect institutional case mix and the associated cost of service. The purpose of the project is to develop a more equitable payment system for long-term care providers than the current flat-rate system for reimbursement of skilled nursing and intermediate care facilities services. The system will build on the results of research conducted in the State of New York. The researchers will also study the long-term care reimbursement systems in Illinois, Maryland, Ohio, and West Virginia, to identify potential problems in implementing a case-mix reimbursement system.

Status: The cooperative agreement was awarded at the end of September 1984. The State of Texas has assigned staff to the project and made initial contacts with the other States. They are now revising and finalizing their research plan.

Evaluability Assessment of the Medicare Prospective Payment System on Long-Term Care

Project No.: 100-84-0032
Period: October 1984 - May 1985
Funding: $ 129,891
Award: Contract
Contractor: Urban Institute
2100 M Street, NW.
Washington, D.C. 20037
Project Officer: Marni Hall
Division of Reimbursement and Economic Studies

Description: This project is funded by the Office of the Assistant Secretary for Planning and Evaluation. The role of the Office of Research and Demonstrations is to serve on a Departmental work group which provides ongoing technical direction and review of the work produced. The purpose of this study is to develop an evaluation strategy for investigating the impact of the Medicare prospective payment system (PPS) on the long-term care population and the long-term care system. The contractor will be responsible for identifying potential patient, facility, and system-level changes that may result from the implementation of the PPS. This study will examine the extent and the manner in which the implementation of PPS has altered demand, utilization, and expenditures for long-term care services. The contractor will also develop methodologies for examining the impact of those changes.

Status: This project has refined and expanded the critical evaluation issues to be explored, reviewed the relevant literature, and prepared an annotated bibliography.

Home Health

Home Health Agency Prospective Payment Demonstration

Project No.: 500-84-0021
Period: December 1983 - December 1988
Funding: $ 1,556,975
Award: Contract
Contractor: Abt Associates, Inc.
1055 Thomas Jefferson Street, N.W.
Washington, D.C. 20007
Project Officer: William Saunders
Division of Long-Term Care Experimentation

Description: The purpose of this project is to develop and test alternative methods of paying home health agencies on a prospective basis for services furnished under the Medicare and Medicaid programs. The demonstration will enable the Health Care Financing Administration to evaluate the effects of various methods of prospective payment on Medicare and Medicaid expenditures, quality of home health care, and home health agency operations.

Status: A contract was awarded in December 1983 to Abt Associates for development and implementation of the demonstration. The initial phase of the project involves the development of the specific payment methodologies; establishment of a research design and evaluation strategy; design of a process to monitor the quality of care provided under the demonstration; development of data collection and status reporting plans; and identification, selection, and training of participating home health agencies. The payment methodologies will then be tested for 3 years to determine the effects on Medicare and Medicaid expenditures, quality of care, and home health agency operations. The operational stage of the demonstration is expected to begin in Summer 1985.

Development of Home Health Agency Competitive Bidding Models

Project No.: 500-84-0033
Period: June 1984 - October 1985
Funding: $ 267,079
Award: Contract
Contractor: Center for Health Policy Studies
5865 Robert Oliver Street
Columbia, Md. 21045
Project Officer: William Saunders
Division of Long-Term Care Experimentation

Description: This project is mandated by Section 6 of the Orphan Drug Act, Public Law 97-414. In the interest of testing purchasing and payment methods that would bring competitive market forces into the health care field, the Health Care Financing Administration has awarded a contract for the development of several models of competitive bidding for home health services under Medicare and Medicaid.

Status: A contract was awarded in June 1984 to the Center for Health Policy Studies to develop several alternative competitive bidding models. The contractor will also develop a research design and evaluation strategy for a possible subsequent demonstration project to test the bidding models. Two draft reports have been received:

- "Review of the Literature and Experience of Competitive Bidding for Health Care Services," October 1984.
- "Market Study for Home Health Care Services," December 1984.

Hospice

Medicare/Medicaid Hospice Demonstration

Period: October 1980 - March 1985

Description: This demonstration was designed to gather data on the cost, utilization, and quality of hospice care with major emphasis on the provision of home care services (for example, continuous nursing care and prescription drugs). There are 26 sites, and each site provides care to terminally ill Medicare beneficiaries and Medicaid recipients having a life expectancy of 6 months or less. An interdisciplinary team approach is utilized to maintain the patient at home in a comfortable, alert, and pain-free state.

Status: Because Public Law 97-248 mandated a Medicare hospice benefit and the extension of the demonstration, each site continues to enroll Medicare beneficiaries. The Medicaid portion of the project ended September 30, 1983. The number of Medicaid participants was unexpectedly small, approximately 363 persons. In contrast, Medicare enrollments have been substantial throughout the demonstration, totaling an estimated 15,000 beneficiaries by September 30, 1984. The Medicare portion of the demonstration is being systematically phased out as the project sites become Medicare certified hospice providers. The final evaluation report by the independent evaluator, Brown University, should be available in early 1985.

Project No.:	95-P-50109/9-02
Award:	Grant
Grantee:	Santa Barbara Visiting Nurse Association 401 North Milpas Street Santa Barbara, Calif. 93101
Project Officer:	Teresa Schoen Division of Long-Term Care Experimentation

Project No.:	95-P-50022/9-02
Award:	Grant
Grantee:	San Diego Hospice Corporation 3243 Mission Village Drive San Diego, Calif. 92123
Project Officer:	Teresa Schoen Division of Long-Term Care Experimentation

Project No.:	95-P-50194/9-02
Award:	Grant
Grantee:	Hospice of Marin 77 Mark Drive, #16 San Rafael, Calif. 94903
Project Officer:	Teresa Schoen Division of Long-Term Care Experimentation

Project No.: 95-P-50148/9-02
Award: Grant
Grantee: Pacifica Home Care
1386-B West Seventh Street
San Pedro, Calif. 90732
Project Officer: Teresa Schoen
Division of Long-Term Care Experimentation

Project No.: 95-P-50149/9-02
Award: Grant
Grantee: Hospital Home Health Care Agency of California
23228 Hawthorne Boulevard
Torrance, Calif. 90505
Project Officer: Teresa Schoen
Division of Long-Term Care Experimentation

Project No.: 95-P-50020/8-02
Award: Grant
Grantee: Boulder County Hospice, Inc.
2825 Marine Street
Boulder, Colo. 80303
Project Officer: Dennis M. Nugent
Division of Long-Term Care Experimentation

Project No.: 95-P-50037/1-02
Award: Grant
Grantee: The Connecticut Hospice, Inc.
61 Burban Drive
Branford, Conn. 06405
Project Officer: Teresa Schoen
Division of Long-Term Care Experimentation

Project No.: 95-P-50120/4-02
Award: Grant
Grantee: Hospice, Inc.
111 N.W. 10th Avenue
Miami, Fla. 33128
Project Officer: Teresa Schoen
Division of Long-Term Care Experimentation

Project No.: 95-P-50079/4-02
Award: Grant
Grantee: Hospice Care, Inc.
3400 70th Avenue North
Pinellas Park, Fla. 33565
Project Officer: Teresa Schoen
Division of Long-Term Care Experimentation

Project No.: 95-P-50083/1-02
Award: Grant
Grantee: Hospice of the Good Shepherd, Inc.
P.O. Box 144
Waban, Mass. 02168
Project Officer: Teresa Schoen
Division of Long-Term Care Experimentation

Project No.: 95-P-50085/1-02
Award: Grant
Grantee: University of Massachusetts Medical Center
Palliative Care Service, Inc.
55 Lake Avenue North
Worcester, Mass. 01605
Project Officer: Teresa Schoen
Division of Long-Term Care Experimentation

Project No.: 95-P-50154/5-02
Award: Grant
Grantee: Bethesda Lutheran Medical Center
559 Capitol Boulevard
St. Paul, Minn. 55103
Project Officer: Dennis M. Nugent
Division of Long-Term Care Experimentation

Project No.: 95-P-50122/7-02
Award: Grant
Grantee: Lutheran Medical Center
2639 Miami Street
St. Louis, Mo. 63118
Project Officer: Dennis M. Nugent
Division of Long-Term Care Experimentation

Project No.: 95-P-50001/2-02
Award: Grant
Grantee: Overlook Hospital
193 Morris Avenue
Summit, N.J. 07901
Project Officer: Teresa Schoen
Division of Long-Term Care Experimentation

Project No.: 95-P-50135/6-02
Award: Grant
Grantee: Hospital Home Health Care, Inc.
500 Walter N.E., Suite 310
Albuquerque, N.Mex. 87102
Project Officer: Dennis M. Nugent
Division of Long-Term Care Experimentation

Project No.: 95-P-50006/2-02
Award: Grant
Grantee: Cabrini Hospice
227 East 19th Street
New York, N.Y. 10003
Project Officer: Teresa Schoen
Division of Long-Term Care Experimentation

Project No.: 95-P-50111/2-02
Award: Grant
Grantee: Genesee Region Home Care Association
311 Alexander Street
Rochester, N.Y. 14604
Project Officer: Teresa Schoen
Division of Long-Term Care Experimentation

Project No.: 95-P-50267/0-02
Award: Grant
Grantee: Providence Medical Center
N.E. 49th and Glisan
Portland, Oreg. 97213
Project Officer: Teresa Schoen
Division of Long-Term Care Experimentation

Project No.: 95-P-50068/6-02
Award: Grant
Grantee: Visiting Nurse Association of Dallas
8200 Brookriver Drive, Suite 200N
Dallas, Tex. 75247
Project Officer: Dennis M. Nugent
Division of Long-Term Care Experimentation

Project No.: 95-P-50147/6-02
Award: Grant
Grantee: St. Benedict Hospital and Nursing Home
323 E. Johnson
San Antonio, Tex. 78204
Project Officer: Dennis M. Nugent
Division of Long-Term Care Experimentation

Project No.: 95-P-50040/1-02
Award: Grant
Grantee: Northern Vermont Respond
Visiting Nurse Association, Inc.
260 College Street
Burlington, Vt. 05401
Project Officer: Teresa Schoen
Division of Long-Term Care Experimentation

Project No.: 95-P-50043/3-02
Award: Grant
Grantee: Hospice of Northern Virginia
4715 North 15th Street
Arlington, Va. 22205
Project Officer: Teresa Schoen
Division of Long-Term Care Experimentation

Project No.: 95-P-50182/3-02
Award: Grant
Grantee: Medical College of Virginia
Box 37, MCV Station
Richmond, Va. 23298
Project Officer: Teresa Schoen
Division of Long-Term Care Experimentation

Project No.: 95-P-50104/0-02
Award: Grant
Grantee: Community Home Health Care
200 West Thomas Street
Seattle, Wash. 98119
Project Officer: Teresa Schoen
Division of Long-Term Care Experimentation

Project No.: 95-P-50121/5-02
Award: Grant
Grantee: Bellin Memorial Hospital
744 South Webster Avenue
Green Bay, Wis. 54305
Project Officer: Dennis M. Nugent
Division of Long-Term Care Experimentation

Project No.: 95-P-50132/5-02
Award: Grant
Grantee: Rogers Memorial Hospital, Inc.
34810 Pabst Road
Oconomowoc, Wis. 53066
Project Officer: Dennis M. Nugent
Division of Long-Term Care Experimentation

National Hospice Study

Project No.: 99-P-97793/1-03
Period: September 1980 - June 1984
Funding: $ 2,890,840
Award: Grant
Grantee: Brown University
Division of Biology and Medicine
Box G
Providence, R.I. 02912
Project Officer: Spike Duzor
Division of Health Systems and Special Studies

Description: This study will evaluate the effects of providing hospice services to terminally ill Medicare and Medicaid patients. It will determine whether hospice care can provide the necessary emotional, psychological, and medical support to the terminally ill which would permit them to remain at home during their final months of illness and eliminate long and costly periods of institutionalization.

Status: The final report is currently being reviewed by the Health Care Financing Administration staff. It is anticipated that this report will be available in Summer 1985. Preliminary results indicate that the hospice concept favorably compares with traditional medical services for quality-of-life outcomes.

Implications of the National Hospice Study for Hospice Prospective Reimbursement

Project No.: 99-C-97793/1-04
Period: May 1984 - April 1985
Funding: $ 191,096
Award: Cooperative Agreement
Awardee: Brown University
Box G
Providence, R.I. 02912
Project: Feather Ann Davis
Officer: Division of Beneficiary Studies

Description: The purpose is to conduct analyses of the interrelationships among the cost, quality of life, and patient characteristic data for the purpose of exploring alternative methods for prospective reimbursement. A composite case-mix measure based on prior utilization, patient characteristics, and informal support factors will be developed. Analyses will be conducted to determine the feasibility of a unique, inpatient hospice, diagnosis-related group (DRG).

Status: The analytic plan has been submitted and approved, as required by the conditions of award. Work is proceeding on schedule.

Hospice Patient Outcomes and Quality of Care

Project No.: 18-C-98615/01
Period: July 1984 - July 1985
Funding: $ 123,870
Award: Cooperative Agreement
Awardee: Hebrew Rehabilitation Center for Aged
Department of Social Gerontological Research
1200 Centre Street
Boston, Mass. 02131
Project Officer: Feather Ann Davis
Division of Beneficiary Studies

Description: The purpose of this research is to contribute to knowledge concerning variations in quality of care by hospices according to type of hospice setting, type of services provided, and other relevant variables. The overall goal is to use two longitudinal data sets to extrapolate findings concerning the relationship between program and personal characteristics, and variations in pain and other symptoms experienced by hospice patients as death approaches.

Status: As of the end of December 1984, no monies had been expended under the cooperative agreement because of problems in obtaining a clear data tape from Brown University (the primary awardee under which the data were collected). A progress report was received in January 1985. A draft analytical report is expected mid-1985.

Population-Based Study of Hospice

Project No.: 18-C-98674/0-01
Period: September 1984 - September 1987
Funding: $ 664,095
Award: Cooperative Agreement
Awardee: Fred Hutchinson Cancer Research Center
1124 Columbia Street
Seattle, Wash. 98104
Project Officer: Feather Ann Davis
Division of Beneficiary Studies

Description: This is a study of utilization among hospice and nonhospice terminal patients; the effect of hospital prospective reimbursement on hospice caseload and length of stay; and hospice penetration of the market. Seven data sets will be linked in order to provide both economy and power. The area under study is 13 counties in western Washington.

Status: The project has just gotten started, having only been awarded in September 1984. The awardee is presently establishing coordination and liaison with the participating hospices and recruiting for a project manager.

Title XVIII Hospice Benefit Program Evaluation and Report to Congress (Medicare)

Funding: Intramural
Project Director: Feather Ann Davis
Division of Beneficiary Studies

Description: This project is congressionally mandated by the Tax Equity and Fiscal Responsibility Act of 1982 (Public Law 97-248) and the Deficit Reduction Act of 1984 (Public Law 93-369). The Secretary is required to prepare and transmit a report to Congress no later than January 1, 1986, which will determine "whether or not the reimbursement method and benefit structure...for hospice care under Title XVIII...are fair and equitable and promote the most efficient provision of hospice care...and any recommendations for legislative changes in the hospice care reimbursement or benefit structure." Specific information will be provided on the current prospective payment system for hospice. The proposed evaluation will address congressional and departmental needs for information on the hospice benefit to make decisions regarding the extension and possible modification of the benefit and the reimbursement mechanism and for ongoing program operation.

Status: The program evaluation plans are being implemented. Associated procurements are anticipated in the second quarter of fiscal year 1985.

Data Development and Analyses

Analysis of Physician Pricing Behavior, Third-Party Administrative Practices

Project No.: 600-76-0058
Period: April 1976 - September 1983
Funding: $ 741,570
Award: Contract
Contractor: Harvard University
School of Public Health
677 Huntington Avenue
Boston, Mass. 02115
Project Officer: William Sobaski
Division of Reimbursement and Economic Studies

Description: This study deals with physician response to reimbursement alternatives, including analysis of price trends, relative values, and relations between medicine and private health insurance.

Status: All interim reports were completed. A draft final report was received in Fall 1984. The study of price trends showed that wide disparities both within and across areas may be concealed by national price trend figures. A unique methodological approach to relative value studies was undertaken that showed large imbalances exist between payments for technological procedures versus primary care. The nonprofit and for-profit private insurance sectors were shown to employ quite different strategies in establishing relationships with medicine, albeit both cover positive relationships. A new model of supply-and-demand factor interactions in the medical market was developed. The final report is expected in Spring 1985.

Aspects of Physician Behavior in Medicare and Medicaid

Project No.: 95-P-97178
Period: September 1978 - December 1983
Funding: $ 730,313
Award: Grant
Grantee: The Urban Institute
2100 M Street, N.W.
Washington, D.C. 20037
Project Officer: William Sobaski
Division of Reimbursement and Economic Studies

Description: This project examines three areas of physician reimbursement:

- Provision of pathology services.
- The effect of reimbursement on physician practice location.
- Simulation and analysis of alternative reimbursement systems.

Status: Work analyzing the effects of reimbursement on physician practice location, the Medicare Economic Index, and Medicare-Medicaid fee levels and differences have been completed. During the fifth year, two ongoing tasks were completed and eight additional tasks involving simulations and behavioral modeling were undertaken, using existing data files. The project terminated in December 1983. A draft final report was received in January 1985.

Alternative Methods for Developing a Relative Value Scale of Physician Fees

Project No.: 500-81-0053
Period: September 1981 - September 1984
Funding: $ 287,557
Award: Contract
Contractor: The Urban Institute
2100 M Street, N.W.
Washington, D.C. 20037
Project Officer: Stephen F. Jencks
Division of Reimbursement and Economic Studies

Description: This project explores criteria and methods underlying relative value scales for physician services. Some of these methods will be applied to approximately 100 procedures to develop relative value scales. The study will address the implications of adopting different construction methods.

Status: Five broad classes of approaches to developing relative value scales are discussed in the first-year report, received in February 1983. These five classes of methods are charge-based, statistical cost function, time-based, micro costing, and group decisionmaking approaches. The contract was extended to permit more adequate evaluation of cost-based approaches to creating relative value scales. A draft final report has been received.

Survey of Physicians' Practice Costs and Incomes: Redesign and Implementation

Project No.: 500-83-0025
Period: June 1983-October 1985
Funding: $ 1,508,942
Award: Contract
Contractor: National Opinion Research Center
6030 South Ellis
Chicago, Ill. 60637
Project Officer: Sherry Terrell
Division of Reimbursement and Economic Studies

Description: This is the fifth national survey of physicians' practice costs and income periodically conducted since 1975. Approximately 5,000 physicians will be queried about their 1983 practice patterns. Project tasks are to update the survey instrument, design the sample and data collection methodology, conduct a pretest, revise the instrument as necessary, and subsequently conduct the survey, compile the data, and produce data tapes, various tabulations, technical documentation, and a final report.

Status: All preliminary design and pretest work was completed by Fall 1984. Interviewing began in October and will continue through May 1985. The survey will update our knowledge of physician practice economics since the last survey in 1978. Besides providing data for the assessment and refinement of the Medicare Economic Index, information relevant to a number of current physician payment issues, such as the extent of participating physicians and relative value of various services, will be available.

Medical Doctor Diagnosis-Related Groups Algorithms

Project No.: 500-84-0024
Period: February 1984 - February 1985
Funding: $ 114,931
Award: Contract
Contractor: Mandex, Inc.
8302D Old Courthouse Road
Vienna, Va. 22180
Project Officer: William J. Sobaski
Division of Reimbursement and Economic Studies

Description: The principal purpose of this project was to obtain statistical algorithms that can be used to improve estimates of the values of physician service resources for inpatient care by diagnosis-related groups calculated from the 1981 Health Care Financing Administration (HCFA) statistical files. In addition, suggestions were made for calculating these values from the 1983 HCFA statistical files and for examining the specialty and locality impact of using national average payment amounts.

Status: The initial planning conference with the Office of Research, Office of Legislation and Policy, and Office of Statistics and Data Management staff was held February 8, 1984. Initial analysis of South Carolina carrier data has led to substantially improved matching of Medicare provider analysis and review and bill summary records being used for intramural studies. Recommendations for estimating cost weights from inpatient hospital bill file and Part B Medicare data file linkage were received. Findings from the study based on the analysis of the merged carrier and intermediary data from two States--South Carolina and Florida--conclude that a physician diagnosis-related group system is not inconceivable. The contractor goes on to say that a few components necessary for the development of such a system are feasible, but the data at hand do not reveal whether such a system would be advisable. The project was terminated February 1985.

Assignment Rates Revisited

Funding: Intramural
Project Director: Alma McMillan
Division of Beneficiary Studies

Description: The level of the assignment rate for physicians' services is of continuing interest. Beneficiaries are affected financially when the physician elects not to accept payment for services on an assigned basis. Data on physician assignment rates through 1978 have been published earlier. This study examines recent trends through 1982 in assignment rates by age, sex, race, and State. Assignment rates by physician specialty are also analyzed, as well as the effect of mandatory assignment, i.e., automatic assignment of charges for Medicaid eligibles.

Status: Preliminary data show that in 1982 about 52 percent of the $17.6 billion in physicians' charges to aged Medicare beneficiaries was assigned; about 70 percent of the $2.2 billion in charges to disabled beneficiaries was assigned. These figures represent an increase from the rate of 47 percent for the aged in 1975 and an increase from the rate of 64 percent for the disabled in 1976. The exclusion of charges for Medicaid eligibles, which are automatically assigned, reduces the assignment rate several percentage points. For aged enrollees, the rate dropped 6 percentage points to 46 percent. The effect of unassigned claims on beneficiary liability is also examined. Inflation-adjusted liability per aged user increased 64 percent from 1975 to 1982 (from $42 to $69). The most important factor behind this increase was the 61-percent increase in inflation-adjusted physician charges during this period. One-fourth of aged users had liability of $100 or more in 1982, and more than one-fifth of disabled users had that much liability.

Development of a Physician-Oriented Data Base

Project No.: 500-83-0046
Period: September 1983 - October 1984
Funding: $ 159,974
Award: Contract
Contractor: Mandex, Inc.
8302D Old Courthouse Road
Vienna, Va. 22180
Project Officer: Benson Dutton
Division of Reimbursement and Economic Studies

Description: This pilot study tested the feasibility of developing a physician (practice) oriented Medicare Part B data base. A small sample of the approximately 600,000 uniquely identified practices were selected with a 1-percent sample of about 6,000 observations with an average of approximately 300 claims per observation. This effort identified provider number selection procedures, estimating any additional costs to the carriers of selecting and writing off practice-specific data.

Status: All of the data received from the four participating carriers have been entered into the Health Care Financing Administration (HCFA) tape management system. There are 100-percent samples of the 1983 files submitted, not a sample data base as suggested in the scope of work. The contractor recommends that any further data collection by HCFA include a cadre of at least two persons and at most four who are fully conversant with the potential sample design options and carrier operations. The second recommendation is that HCFA collect the physician-oriented data base files on a 100-percent basis. The final report is available from the National Technical Information Service, accession number PB85 163087.

Further Analysis of the Medical Doctor Diagnosis-Related Groups Algorithms

Project No.: 500-85-0023
Period: April 1985 - November 1985
Funding: $154,734
Award: Contract
Contractor: Mandex, Inc.
8302D Old Courthouse Road
Vienna, Va. 22180
Project Officer: Benson Dutton
Division of Reimbursement and Economic Studies

Description: This project is an extension of Contract Number 500-84-0024. Section 603 of Public Law 98-21, the Social Security Amendments of 1983, required that the Department of Health and Human Services begin collecting data for calculating the cost of physician services related to inpatient care of beneficiary cases classified by diagnosis-related group (DRG), and to report on the feasibility of a DRG-like system for Medicare payment for such physician services.

Status: In August 1983, a contract was awarded resulting from an unsolicited proposal received from Mandex, Inc., to develop statistical algorithms for calculating the value of physician services related to inpatient stays categorized by DRG. This contract is a continuation of that effort and specifically, the contractor shall complete the following tasks:

- Acquisition of the 1983 Medicare Part B Data File from selected carriers.
- Acquisition of 100-percent Medicare Part B patient data of claims paid for services provided during 1984 from selected carriers.
- Examination of linked Part A and Part B data for a selection of medical and surgical DRG's.
- Examination of the redistributive effects of payments at DRG average levels by specialty.
- Examination of the redistributive effects of the schedule average payments.

Prospective Payment of Physicians

Funding: Intramural
Project Director: Stephen F. Jencks
Division of Reimbursement and Economic Studies

Description: Section 603 of Public Law 98-21, Social Security Amendments of 1983, requires the Secretary, Department of Health and Human Services, during fiscal year 1984, to begin the collection of data necessary to compute, by diagnosis-related groups (DRG's), the amount of physician charges for services furnished to hospital inpatients classified in those DRG's. A Report to Congress due in 1985 must include recommendations on the advisability and feasibility of determining payment for inpatient physicians' services on a DRG-type classification. Public Law 98-369 specified the due date as July 1, 1985.

Status: Intramural work has begun to examine the level and stability of outlays for physician services by DRG's in Medicare claims data samples. This initial work will emphasize regional, specialty, and type of service patterns for high frequency DRG's. As larger data sets become available, analyses will expand to the remaining DRG's. Data file construction and specification of data display tables to be produced began in June 1983. A grant to study DRG-based physician reimbursement schemes was awarded to the Center for Health Economics Research in September 1983. This work is being conducted in close coordination with contracts on this topic. Substantive work on the subject is also in progress as part of a cooperative agreement with the Brandeis University Health Policy Research Consortium and under a cooperative agreement with Project Hope. A conference on HCFA-sponsored physicians-payment research was sponsored by Project Hope in January 1985.

Other Physician Payment

Physician Reimbursement and Continuing Care under Medicaid in Suffolk County, New York

Project No.:	11-C-98052/2-04
Period:	September 1981 - December 1986
Funding:	$ 791,766
Award:	Cooperative Agreement
Awardee:	New York Department of Social Services Division of Medical Assistance 40 North Pearl Street Albany, N.Y. 12243
Project Officer:	Sherrie Fried Division of Health Systems and Special Studies

Description: This demonstration is designed to test the impact of alternative methods of physician reimbursement on the provision of continuing care for Medicaid children in Suffolk County, N. Y. The methods include the current fee schedule, a fee-for-service/continuing care method that reimburses physicians at a higher rate for accepting continuing comprehensive care, and a comprehensive prepayment plan.

Status: The project began the operational phase in July 1983. Major milestones include approval by the Health Care Financing Administration of the continuation request; development of capitation rates and an augmented fee schedule; development of claim payment, data collection, and management reporting systems; and enrollment of physicians and recipients. A 12-month, no-cost extension was approved to extend the demonstration until December 1986. Active enrollment of children and physicians ended May 1, 1984. As of July 1984, 3,465 children and 75 physicians were participating in the demonstration.

Impact of Physician Supply and Regulation on Physician Fees and Utilization of Services

Project No.: 18-P-97619/5
Period: March 1980 - November 1985
Funding: $ 408,287
Award: Grant
Grantee: Blue Cross/Blue Shield of Michigan
20800 Greenfield
Oak Park, Mich. 48237
Project Officer: Benson Dutton
Division of Reimbursement and Economic Studies

Description: Blue Cross and Blue Shield of Michigan (BCBSM) has used paid claims files to examine the issue of physician-induced demand. BCBSM has also examined market areas in Michigan with private and Medicare-paid claims from 1975 to 1980. In addition, the study is investigating the impact of physician supply and regulation on the price and quantity of physician services. To supplement the paid-claims data, BCBSM has surveyed a sample of Michigan physicians to determine amenities, workload/hours, non-Blue Shield volume, and charges. This project will describe and analyze variation in per capita use across market areas. BCBSM is using patient illness diagnostic tracers from physician billing data. The inducement hypothesis is to be tested using a "Reinhardt test" of physicians' fees while holding relevant supply, demand, and amenities variables constant.

Status: The study identified 15 market areas in Michigan and showed that there were major differences between market areas in use rates as well as the growth in those rates. The areas with the highest use rates in 1975 were also the markets with the highest growth in use. On induced demand, the data support the hypothesis that an increase in the availability of doctors increases the use of services, but the evidence refutes the target-income hypothesis by showing that fees move toward competitive levels. BCBSM interim reports were very useful in resolving the clinic locality issue in Michigan raised by Congressman Robert Davis (R-MI) in 1982. Other reports received include:

- "Medicare Assignment Rates in Michigan."
- "The Effects of Physician Availability on Fees and the Demand for Doctors' Services."
- "Survey of Michigan Physicians' Practice Characteristics."
- "Medicare Fees, Use, and Assignment Rates in Michigan's Physician Service Markets."
- "Fees or Use? What's Responsible for Rising Health Care Costs?"
- "The Determination of Medicare Market Areas and Medicare Fees, and Use in Michigan."

A final report is expected in late 1985.

Creating Diagnosis-Related-Group-Based Physician Reimbursement Schemes: A Conceptual and Empirical Analysis

Project No.: 15-C-98387
Period: September 1983 - June 1985
Funding: $ 503,424
Award: Cooperative Agreement
Awardee: Center for Health Economics Research
824 Boylston Street
Chestnut Hill, Mass. 02167
Project Officer: Stephen F. Jencks
Division of Reimbursement and Economic Studies

Description: Under this project, conceptual analyses will explore alternative diagnosis-related-group-based physician payment schemes, using alternative packaging methods developed under an earlier Health Care Financing Administration contract. Empirical analyses will be conducted using Medicare Part A and Part B data for New Jersey, North Carolina, and Michigan, and Medicaid data from New Jersey.

Status: A first-year report on data from North Carolina and New Jersey has been delivered. An interim report on data from all four States has been received.

Economics of Diagnosis-Related-Group-Based Physician Reimbursement

Project No.: 18-C-98567/3-01
Period: July 1984 - October 1985
Funding: $ 154,966
Award: Cooperative Agreement
Awardee: Project Hope
Millwood, Vir. 22646
Project Officer: Stephen Jencks
Division of Reimbursement and Economic Studies

Description: Project Hope will prepare a critical literary review and three papers on issues surrounding application of diagnosis-related groups to physician reimbursement, conduct a conference on Health Care Financing Administration-sponsored physician research, and conduct a small working conference on future research in this area.

Status: All papers are in preparation, drafts or outlines have been received, and a public conference on research was conducted in January 1985.

Channeling

Evaluation of Coordinated Community-Oriented, Long-Term Care Demonstration

Project No.: 500-80-0073
Period: September 1980 - September 1984
Funding: $ 2,373,876
Award: Contract
Contractor: Berkeley Planning Associates
3200 Adeline Street
Berkeley, Calif. 94703
Project Officer: Kathy Ellingson
Division of Long-Term Care Experimentation

Description: This long-term care project evaluates a series of demonstration projects on the delivery of coordinated community care services. The demonstrations test whether care tailored to clients' needs can keep them in the community instead of moving them into expensive institutional care settings.

Status: The contractor has completed draft case studies for the participating projects. These case studies highlight the history and origin of the project, describe project organization, and discuss operation issues. A final report is expected in Spring 1985 that will focus on quality-of-care and cost-effectiveness issues.

National Long-Term Care Channeling Demonstrations

Period: September 1980 - May 1985

Description: This is a major national research and demonstration program. It is a combined effort of three components in the Department of Health and Human Services: the Health Care Financing Administration (HCFA); the Office of the Assistant Secretary for Planning and Evaluation, Office of the Secretary; and the Administration on Aging, Office of Human Development Services. The program is testing whether and to what extent the long-term care needs of elderly impaired persons can be met in a cost-effective way through a community-based system of comprehensive needs assessment, care planning, and case management. These components are the core channeling services. Five of the projects were designated as "complex-model projects." These projects alter the basic channeling model by adding three program elements under HCFA waivers: expanded Medicare and Medicaid service coverage, authorization to approve reimbursement for services, and limitations on per capita expenditures. Project sites are preparing transition plans for phase down of the demonstration between July 1, 1984 and March 31, 1985.

Project Nos.:	11-P-98211/4-02 HHS-100-80-0136
Funding:	$ 932,896
Contractor/ Grantee:	Florida Department of Health and Rehabilitative Services 1317 Winewood Boulevard Tallahassee, Fla. 32301
Project Officer:	William Saunders Division of Long-Term Care Experimentation

Status: The Miami Jewish Home and Hospital for the Aged has been designated as the organization responsible for implementing the Florida project. This site has been selected as a complex-model project. The project catchment area includes the city of Miami and several surrounding communities. The project began serving clients in May 1982, and is serving a caseload of 450 clients. The State is now planning a transition of the project to an ongoing State-funded program after demonstration services end in March 1985.

Project No.:	HHS-100-80-0138
Funding:	$ 700,000
Contractor:	Kentucky Cabinet for Human Resources 275 East Main Street Frankfort, Ky. 40621
Project Officer:	William Saunders Division of Long-Term Care Experimentation

Status: The Kentucky Department for Social Services has been designated as the agency responsible for implementing the Kentucky project. This site has been selected as a basic-model project. The project catchment area covers eight rural counties in eastern Kentucky. The project began serving clients in February 1982, and is serving a caseload of 250 clients. The State is now preparing for transition of the project to an ongoing, State-funded program by April 1, 1985.

Project No.: HHS-100-80-0139
Funding: $ 609,839
Contractor: Maine Department of Human Services
State House, Station II
Augusta, Maine 04333
Project Officer: Leslie Saber
Division of Long-Term Care Experimentation

Status: The Maine demonstration site is a basic-model project administered under a subcontract with Southern Maine Senior Citizens, Inc., an Area Agency on Aging in Portland. The two-county catchment area, Cumberland and York Counties, covers 2,000 square miles. The project began serving clients in February 1982, and reached an active caseload of 216 clients by the end of July 1983. Through funding support from the State and sponsoring area agency, all appropriate clients will continue to receive the case-management services and expanded community-based services. The site expects the transition to begin in January 1985.

Project Nos.: 11-P-98210/1-02
HHS-100-80-0141
Funding: $ 1,657,617
Contractor/ Grantee: Massachusetts Department of Public Welfare
600 Washington Street
Boston, Mass. 02111
Project Officer: Leslie Saber
Division of Long-Term Care Experimentation

Status: The Massachusetts channeling demonstration is a complex-model site operated by Greater Lynn Senior Services. The catchment area includes Greater Lynn and the Beverly area. The project began serving clients in May 1982. The project reached its target caseload of 300 clients by the end of July 1983. The project is planning to continue providing services to Medicaid clients under a Section 2176 (home- and community-based services) waiver.

Project No.: 11-P-98213/2-02
Grantee: New York State Department of Social Services
40 North Pearl Street
Albany, N.Y. 12243
Project Officer: Thomas M. Kickham
Division of Long-Term Care Experimentation

Status: The Rensselaer County Department for the Aging has been designated as the agency responsible for implementing the New York project. This site has been selected as a complex-model project. The project catchment area is Rensselaer County, N. Y. The project began serving clients in May 1982 and currently is serving a caseload of 200 clients. The project is preparing a plan for an orderly winddown by March 31, 1985; clients will be transferred to existing long-term care resources in the community.

Project No.: 11-P-98209/5-02
Grantee: Ohio Department of Public Welfare
30 East Broad Street
Columbus, Ohio 43215
Project Officer: Thomas M. Kickham
Division of Long-Term Care Experimentation

Status: The Cuyahoga County Board of Commissioners has been designated as the agency responsible for implementing the Ohio project. The project site is administered by the Western Reserve Area Agency on Aging. The project catchment area covers Cuyahoga County, which consists of the city of Cleveland and surrounding suburbs. The project began serving clients in May 1982, and is serving a caseload of 415 clients. The State expects to submit its final transition/termination plan by July 1984. After the demonstration, the State will continue funding the program for channeling clients.

Project Nos.: 11-P-98212/3-02
HHS-100-80-0146
Funding: $ 2,235,982
Contractor/ Grantee: Pennsylvania Department of Public Welfare
Health and Welfare Building
Harrisburg, Pa. 17120
Project Officer: Leslie Saber
Division of Long-Term Care Experimentation

Status: The Pennsylvania channeling project is operated through a subcontract with the Philadelphia Corporation for Aging. This site is a fully centralized complex model project site. The catchment area covers more than 129 square miles and includes the city and county of Philadelphia. The project began serving clients in May 1982. By the middle of June 1983, the project reached its target caseload of 500 clients. A final transition/termination plan was submitted at the beginning of June 1984. The State expects to continue serving clients under a State-funded preadmission screening case-management program.

Community-Based Care

Multipurpose Senior Services Project

Project No.: 11-P-97553/9-04
Period: October 1979 - March 1984
Award: Grant
Grantee: State of California Health and Welfare Agency
1600 Ninth Street
Room 460
Sacramento, Calif. 95814
Project Officer: Michael J. Baier
Division of Long-Term Care Experimentation

Description: The purpose of this project was to reduce clients' hospital and skilled nursing facility days, to reduce total expenditures by social and health services for clients, and to improve clients' functional abilities. Service delivery was administered through eight separate demonstration sites located throughout the State. Each site has an average of 60 organizations with which they contract for the provision of direct services to clients. A wide range of waivered health and social services are provided under the project.

Status: The project terminated on March 31, 1984. The project secured approval of a Section 2176 home- and community-based waiver program beginning July 1, 1983, and approximately 35 percent of this project's 1,900 experimental clients were determined eligible for that program. The project's final report was received in September 1984 and is under review.

Demonstration of Community-Wide, Alternative Long-Term Care Model

Project No.: 11-P-90130/2-09
Period: July 1976 - July 1986
Funding: $ 960,938
Award: Grant
Grantee: New York State Department of Social Services
40 North Pearl Street
Albany, N.Y. 12243
Project Officer: William Saunders
Division of Long-Term Care Experimentation

Description: The New York State Department of Social Services is demonstrating alternative approaches to delivering and financing long-term care to the adult disabled and elderly Medicaid population of Monroe County, N. Y. The project has developed the Assessment for Community Care Services (ACCESS) model as a centralized unit responsible for all aspects of long-term care for Monroe County residents 18 years of age or over who are eligible for Medicaid and have long-term health care needs. ACCESS staff provide each client with comprehensive needs-assessment and case-management services.

Status: The project received waivers to permit provision of certain community long-term care services not normally provided under Medicaid in New York. Since the project became operational in 1977, more than 21,000 people with potential long-term care needs have received assessments under this program. The demonstration has been extended until 1986. The extension will allow time to study effects on the health care system in Monroe County.

Continued Demonstration of a Long-Term Care Center Through Inclusion and Expansion of Title XVIII

Project No.: 95-P-97254/2-04
Period: August 1980 - July 1986
Funding: $ 2,308,619
Award: Grant
Grantee: Monroe County Long-Term Care Program, Inc.
55 Troup Street
Rochester, N.Y. 14608
Project Officer: William Saunders
Division of Long-Term Care Experimentation

Description: The purpose of this demonstration is to expand the alternative long-term care delivery model Assessment for Community Care Services (ACCESS) developed for the Medicaid population in Monroe County, N. Y., to include the county's Medicare population. The addition of this Medicare project is for the purpose of working toward an integration of Medicare and Medicaid long-term care services.

Status: The project began operations in October 1982. The Health Care Financing Administration has contracted with New York Blue Cross to serve as Medicare fiscal intermediary for the demonstration. Thus far, more than 6,000 Medicare beneficiaries with potential long-term care needs have received assessments from the project. The demonstration has been extended until 1986 to evaluate the project's effects on the health care system in Monroe County.

Home Services for Functionally Disabled Adults

Project No.: 18-P-97462/2-03
Period: June 1980 - January 1985
Funding: $ 488,075
Award: Grant
Grantee: Community Service Society
Institute for Social Welfare Research
105 East 22nd Street
New York, N.Y. 10010
Project Officer: Marni Hall
Division of Reimbursement and Economic Studies

Description: Functionally disabled, low-income adults are being followed for 12 months after acute hospitalization to determine the impact of ongoing home-service programs. Access to services, quality of services delivered, participation of informal supports, quality of circumstances, durability of independent living arrangements, and public costs will be examined. Data for this project include survey data and Medicare and Medicaid expenditure data.

Status: All of the data for this project have been gathered and the grantee is reconciling the expenditure data from various sources and matching it with respondent service reports. Initial findings from preliminary data analyses indicate that the majority (60 percent) of the disabled elderly in this study were discharged from hospitals without having home services arranged for them by the hospitals. The hospitals in this study used their limited resources to arrange for suitable placements of institution-bound patients rather than those who were being discharged to their homes. The project ended January 1, 1985. A final report is expected in early 1985.

New York State's Long-Term Home Health Care Program

Project No.:	11-P-97155/2-05
Period:	September 1978 - March 1984
Funding:	$ 225,688
Award:	Grant
Grantee:	New York State Department of Social Services 40 North Pearl Street Albany, N.Y. 12243
Project Officer:	Leslie Saber Division of Long-Term Care Experimentation

Description: This program provides an alternative to institutionalization for Medicaid clients who meet the medical criteria for skilled nursing facilities (SNF's) or intermediate care facilities (ICF's). A maximum expenditure for home care has been set at 75 percent of the going rate in a locale for SNF or ICF levels of care for which the client is eligible. The program objectives include promoting cost containment by reducing fragmentation in the provision of home care services through a single entry system that coordinates and provides these services.

Status: Currently there are more than 30 provider sites in operation. The Health Care Financing Administration approved the project's fifth and final year through March 1984. The final year allowed time to complete reassessments, prepare a final report, transmit data to the evaluator, and expand the program statewide under the authority of Section 2176 (home and community-based services program). In December 1982, the program began statewide expansion. The State submitted a draft report in February 1984 and expects to submit a final report in Winter 1985. The timeframe for the completion of the report has been extended because of extensive involvement by the State staff in reviewing the final report of the project's evaluation by Abt Associates Inc., which was submitted to the State in December 1984.

Evaluation of New York State's Long-Term Home Health Care Program

Project No.: 500-79-0052
Period: September 1979 - March 1984
Funding: $ 742,694
Award: Contract
Contractor: Abt Associates, Inc.
55 Wheeler Street
Cambridge, Mass. 02138
Project Officer: Kathy Ellingson
Division of Long-Term Care Experimentation

Description: The Long-Term Home Health Care Program (LTHHCP) was designed to offer coordinated, comprehensive, home health care services through a single health care provider to Medicaid-eligible aged or disabled individuals in need of skilled nursing or health-related facility care. The major evaluation objective was to determine whether or not LTHHCP provided an alternative to institutional care in terms of cost, service use, and health outcomes. The research was designed to identify 700 program participants and 700 comparison participants, and follow the individuals for at least 1 year by collecting cost and utilization data and applying a health-assessment instrument at three points in time. The data collected was on Medicare, Medicaid, food stamps, energy assistance, public assistance, and supplemental security income. The final analysis compared total public expenditures for the program participants with those of the comparison population, providing measures of health status outcome for both groups.

Status: A descriptive analysis of the program was completed in March 1983 and the final report was received in December 1984. Specific findings were:

- Participation in LTHHCP improved patient survival and maintained or improved physical functioning compared with what would have occurred had they not enrolled.

- LTHHCP clients received two to five times the volume of home care service that might have been expected had they not enrolled. The program effect on home care use was more than twice as large in New York City program sites as in upstate areas. These differences were larger than can be explained by differences in patient mix of clients in the two regions. The study was not able to examine issues of appropriateness or necessity, though results do show that favorable health outcomes were observed in upstate sites with smaller investments in home care services.

- LTHHCP enrollees statewide used about 90 percent less nursing home services than they would have in the absence of the program. However, absolute levels of program savings upstate were more than twice as high as in New York City because of higher levels of nursing home use upstate. Thus, there was greater potential for reducing nursing home use upstate through the program. Rates of hospital inpatient utilization were not affected by the program.

- LTHHCP reduced health care expenditures for enrollees in the upstate New York programs by about $270 a month, per enrollee. In New York City, the program increased health care spending by $447 a month, per enrollee. Virtually all financial benefit (or burden) accrued to Medicaid rather than Medicare.

South Carolina Community Long-Term Care Project

Project No.:	99-P-97493/4-04
Period:	September 1979 - December 1984
Award:	Grant
Grantee:	South Carolina Department of Social Services P.O. Box 1520 Columbia, S.C. 29202-9988
Project Officer:	Leslie Saber Division of Long-Term Care Experimentation

Description: Through Medicaid and Medicare waivers, the State is conducting a demonstration in three counties to test community-based client assessment, coordination of services, and provision of alternative services. It is anticipated that these waivers will increase the use of home care services, thereby reducing reliance on hospitals and lowering the incidence of conversion from Medicare to Medicaid in nursing homes.

Status: The project currently has 651 experimental clients and 535 control group clients. In September 1983, the Health Care Financing Administration (HCFA) approved the State's request for a 15-month continuation through December 1984. The State began implementation of the Medicare waivers in Spring 1983. The project is conducting an internal evaluation to determine the cost effectiveness of community-based services in meeting the needs of the elderly. In November 1983, the project submitted a preliminary report to HCFA on the first-year cohort after 18 months of project participation. This report indicates that the project is targeting on a functionally impaired population whose Medicaid costs are less than the Medicaid costs for the control group. In March 1984, the State submitted a final transition/termination plan. The State has begun an orderly transition from the project to the statewide system that has been implemented under the authority of Section 2176 waivers. By the end of May 1984, the project discharged 323 experimental clients and 290 control clients who could not meet the eligibility criteria for the statewide Section 2176 program. The project expects to submit a final report by Spring 1985.

Modifications of the Texas System of Care for the Elderly: Alternatives to the Institutionalized Aged

Project No.: 11-P-97473/6-05
Period: January 1980 - December 1985
Award: Grant
Grantee: Texas Department of Human Resources
706 Banister Lane
Austin, Tex. 78769
Project Officer: Michael J. Baier
Division of Long-Term Care Experimentation

Description: The purpose of this project is to reduce the growth of nursing homes in Texas and, at the same time, expand access to community care services for needy Medicaid individuals. It is being accomplished by directly changing the operating policies of the State's Title XIX and XX programs; in particular, by eliminating the State's lowest level of institutional care--intermediate care facility (ICF) II. Existing organizations responsible for the State's Title XIX and XX programs are responsible for project implementation.

Status: The project is in its fifth year. In March 1980, there were 15,486 individuals in the ICF-II group. As of July 1984, the number of ICF-II clients declined to 5,000. The total nursing home population also decreased from March 1980 to July 1984, from 64,643 clients to 55,490 clients. The community care program now provides services to many more people, most of whom have medical and functional needs similar to those of the ICF-II recipients or higher level-of-care needs.

Long-Term Care Demonstration Project of North San Diego County

Project No.: 95-P-97325/9-04
Period: September 1979 - January 1984
Funding: $ 1,063,463
Award: Grant
Grantee: Allied Home Health Association, Inc.
4525 Mission Gorge Place
San Diego, Calif. 92120
Project Officer: Michael J. Baier
Division of Long-Term Care Experimentation

Description: The purpose of the project was to demonstrate that a Medicare-certified provider of home health services is an appropriate and cost-effective resource for the administration of a long-term care system. The project compared client benefits and costs of existing long-term care services with those provided under the project for 500 Medicare beneficiaries. Case-management and client-assessment services were provided by the grantee, and waivered services were provided by 19 suppliers of health and social services.

Status: The project officially ended January 15, 1984. The grantee's final report was received in late April 1984. The executive summary and final report are available from the National Technical Information Service, accession numbers PB85-103935 and PB85-103091, respectively.

Delivery of Medical and Social Services to the Homebound Elderly: A Demonstration of Intersystem Coordination

Project No.:	18-P-97492/2-03
Period:	November 1979 - March 1984
Funding:	$ 599,358
Award:	Grant
Grantee:	New York City Department for the Aging 280 Broadway New York, N.Y. 10007
Project Officer:	Michael J. Baier Division of Long-Term Care Experimentation

Description: The purpose of the project was to document the characteristics of a homebound elderly population in New York City, assess their health care needs, and estimate the costs of delivering needed care. A coordinated health care delivery model was established to carry out this project on behalf of the 400 experimental Medicare clients. The project organization included a project advisory committee that was comprised of representatives of relevant city departments and four neighborhood-based service delivery sites.

Status: The project terminated on March 31, 1984. The grantee's final project report was received in May 1984. The executive summary and final report are available from the National Technical Information Service, accession numbers PB85-111169 and PB85-111177, respectively.

Ancillary Community Care Services: A Health Care System for Chronically Impaired Elderly Persons

Project No.: 11-P-97438/4-04
Period: October 1979 - June 1984
Award: Grant
Grantee: Florida Department of Health and Rehabilitative Services
1317 Winewood Boulevard
Tallahassee, Fla. 32301
Project Officer: Leslie Saber
Division of Long-Term Care Experimentation

Description: The State is conducting a Medicaid demonstration project in five counties. The purpose of the project is to develop and test ancillary community care services for the chronically impaired elderly 60 years of age and over. All eligible clients receive a comprehensive medical-social assessment administered by a physician and social worker. The participating counties are responsible for developing client-care plans based on the assessment, conducting case management, and contracting for services with local providers.

Status: The total number of project participants is 971, with 761 randomly assigned to the experimental group and 210 assigned to the control group. All sites reached full caseload by June 1982. The project is currently in its final year. In April 1983, the project sites began working with community agencies to develop an orderly plan for transferring clients from the project to the existing service delivery system. In May 1983, the State submitted an interim report describing the project's research design and base-line data. The final evaluation report was submitted in October 1984. The report is currently under review by the Health Care Financing Administration.

Systematic Examination of Factors that Promote Home Care by the Family

Project No.: 18-C-98385/5-02
Period: September 1983 - September 1986
Funding: $ 393,153
Award: Cooperative Agreement
Awardee: Abbott Northwestern Hospital, Inc.
Planning and Marketing Department
800 East 28th Street at Chicago Avenue
Minneapolis, Minn. 55407
Project Officer: Marni Hall
Division of Reimbursement and Economic Studies

Description: The primary purpose of this project is to describe the role of urban and rural family members in providing home care to frail and chronically ill relatives. It will assess the impact that formal support systems, such as health and social services, have on the promotion of home care. Detailed data will be collected on the caregiving experiences of families of persons meeting the study criteria of advanced age, impairment, living in a private home, and family contacts.

Status: Data collection for this project is currently underway.

Assess (State) Tax Incentives as a Means of Strengthening the Informal Support System for the Elderly

Project No.: 99-C-98410/9-02
Period: September 1983 - September 1986
Funding: $ 387,454
Award: Cooperative Agreement
Awardee: Center for Health and Social Services Research
155 South El Molino
Pasadena, Calif. 91101
Project Officer: Sherry A. Terrell
Division of Reimbursement and Economic Studies

Description: The purpose of this project is to study selected State (Arizona, Idaho, Iowa, and Oregon) tax incentives that are believed to stimulate the informal caregiver system and reduce either current or anticipated demands on the formal long-term care system. Specific objectives are:

- To describe and analyze tax incentives that have been implemented in selected States.
- To develop a predictive model to identify those persons in the general elderly population and their informal caregivers who are likely to take advantage of tax incentives.
- To determine the potential impact of the tax incentive programs in preventing or delaying institutionalization.

Status: The project is in its second year. Four Tax Commissioners and their departments have accepted major roles in the study. Favorable study circumstances were found in Idaho where, in 1982, more than 700 individuals claimed deductions or credits. The Idaho tax incentive program cost the State an estimated $65,900 in lost revenue or about $93.00 per claimant. From preliminary examination of Idaho data, the elderly dependent is characterized as being the widowed mother or mother-in-law of the claimant. She is over 80 years of age, has one or more chronic health conditions, and would likely be dependent on public assistance if the informal support system was disrupted. Claimants are generally married with beginning health problems of their own. They are somewhat older than the average Idaho population and nearing retirement age. Data collection in a second State is scheduled to begin during the second year.

Respite Care Co-Op for Impaired Elderly

Project No: 18-C-98398/5-02
Period: September 1983 - September 1986
Funding: $ 128,880
Award: Cooperative Agreement
Awardee: Southcentral Michigan Commission on Aging
2401 E. Milham Road
Kalamazoo, Mich. 49002
Project Officer: Jean L. Bainter
Division of Long-Term Care Experimentation

Description: This feasibility study has developed a model cooperative to provide respite for family caregivers of impaired elderly. Family members pay for care received with care given. The objectives are to study the feasibility and cost of establishing a model cooperative designed to prevent exhaustion of family members, to eliminate the need for more intensive and/or expensive care, and to prevent unnecessary institutionalization of the elderly.

Status: Through the combined efforts of the project coordinator, an Advisory Committee, and outside consultants, policies and procedures were developed, manuals prepared, and a co-op begun. Issues such as caregiver training, care receiver characteristics (such as mobility, orientation/disorientation, etc.), legal implications of providing care, and insurance coverage were thoroughly investigated. There has been an intensive informative media campaign in the Kalamazoo area. An outside evaluator will address issues regarding the development and implementation of this model, as well as those regarding its outcomes.

On Lok's At-Risk, Capitated Payment Demonstration

Project Nos.:	95-P-98246/9-01 11-P-98334/9-01
Period:	November 1983 - November 1986
Award:	Grant
Grantees:	On Lok Senior Health Services 1441 Powell Street San Francisco, Calif. 94133 and California Department of Health Services 714-744 P Street Sacramento, Calif. 95814
Project Officer:	Jean L. Bainter Division of Long-Term Care Experimentation

Description: As mandated by Public Law 98-21, Section 603(c)(1) and (2), the Health Care Financing Administration (HCFA) granted Medicare waivers to the On Lok Senior Health Services and Medicaid waivers to the California Department of Health Services to permit On Lok to implement a 3-year, at-risk, capitated payment demonstration. Building on On Lok's already established and operating Community Care Organization for Dependent Adults, this new demonstration has modified On Lok's reimbursement mechanism, and all services to the frail and elderly population are being paid for by a predetermined capitated rate from both Medicare and Medicaid (Medi-Cal).

Status: A contract has been signed between On Lok and the California Department of Health Services to permit a Medi-Cal capitated payment to On Lok. Medicare's reimbursement is based on the adjusted average per capita cost with all participants in the ratebook's institutionalized cells. During the first year, HCFA was at risk up to a predetermined dollar amount on the Medicare side, and On Lok was at total risk under Medi-Cal. For the remainder of the grant period, On Lok is assuming total risk under both Medicare and Medi-Cal. For those who are not covered by one or both of these programs, a copayment system has been developed and is being implemented.

Incentive Reimbursement Plan for Medicaid Home Health Services

Project No.: 11-C-98549/1-01
Period: December 1984 - November 1986
Funding: $ 147,292
Award: Cooperative Agreement
Awardee: State of Connecticut
Department of Income Maintenance
110 Bartholomew Avenue
Hartford, Conn. 06106
Project Officer: Michael J. Baier
Division of Long-Term Care Experimentation

Description: This 2-year project proposes to reward Medicaid clients for using lower cost home health agency services through the payment of rebates. The overall purpose is to test whether the granting of rebates will result in more cost-effective use of home health services. The project will include 1,200 Medicaid clients in Hartford, Conn. who are in need of home health care. The project will also measure the impact on patient functional status, health, and client satisfaction.

Status: The project was awarded in November 1984 for the first of 2 project years. The first-year period began December 1, 1984, and extends through November 30, 1985. As of December 30, 1984, the State of Connecticut, the awardee for this project, was in the process of hiring staff and performing other preliminary work necessary to move the demonstration into an operational phase.

Deinstitutionalization of the Chronically Mentally Ill

Project Officer: Jean L. Bainter
Division of Long-Term Care Experimentation

Description: This project is a joint effort between the Departments of Housing and Urban Development (HUD) and Health and Human Services under the Demonstration for Deinstitutionalization of the Chronically Mentally Ill. HUD is providing loans for the construction of community-based housing under Section 202, and rental assistance under Section 8. The Health Care Financing Administration is providing Medicaid waivers to permit reimbursement for a 3-year period for services such as case management, life skills training, supervision, and transportation.

Status: To date, 12 States have submitted Section 1115 waiver-only applications and received approval. There are now 39 sites in operation serving approximately 430 residents. Additional sites are in operation in States not seeking waivers. Several levels of evaluation have been carried out, resulting in Section 202 standards and criteria for small, scattered site housing. The standards include service requirements for this population that must be monitored by the State Mental Health Authority. To date, there are no findings relating to the cost effectiveness of the demonstration.

A Model Addressing the Residential Needs of the Chronically Mentally Ill

Project No.: 11-P-98117/6-03
Period: July 1982 - May 1987
Award: Grant
Grantee: Arkansas Department of Human Services
Seventh and Main Streets
Little Rock, Ark. 72201

Effective and Efficient Community Support Services for the Chronically Mentally Ill

Project No.: 11-P-98000/3-04
Period: September 1981 - December 1986
Award: Grant
Grantee: Office of Health Care Financing
1331 H Street N.W., Fifth Floor
Washington, D.C. 20005

Cost-Effective Community Alternatives to Institutionalization of the Chronically Mentally Ill

Project No.: 11-P-97575/4-05
Period: April 1981 - March 1986
Award: Grant
Grantee: Georgia Department of Medical Assistance
Suite 1266, West Tower
2 Martin Luther King Drive
Atlanta, Ga. 30334

Cost-Effective Comprehensive Community Residential Treatment of the Chronically Mentally Ill

Project No.: 11-P-98242/1-03
Period: November 1982 - May 1987
Award: Grant
Grantee: Maine Department of Human Services
221 State Street
Augusta, Maine 04333

Housing and Urban Development Demonstration Program for the Chronically Mentally Ill

Project No.: 11-P-97563/5-05
Period: May 1980 - September 1985
Award: Grant
Grantee: Minnesota Department of Human Services
658 Cedar Street
St. Paul, Minn. 55155

Cost-Effective Community Alternatives to Deinstitutionalization of the Chronically Mentally Ill

Project No.: 11-P-98100/1-03
Period: November 1982 - June 1987
Award: Grant
Grantee: New Hampshire Division of Welfare
Hazen Drive
Concord, N.H. 03301

Services in Housing and Urban Development Transitional Housing for Chronically Mentally Ill

Project No.: 11-P-97799/2-03
Period: August 1982 - July 1986
Award: Grant
Grantee: New Jersey Department of Human Services
Division of Medical Assistance
222 South Warren Street
Trenton, N.J. 08625

Deinstitutionalization of the Chronically Mentally Disabled, Cost-Effective Community Alternatives

Project No.: 11-P-98118/1-03
Period: June 1982 - May 1987
Award: Grant
Grantee: Department of Social and Rehabilitative Services
600 New London Avenue
Cranston, R.I. 02920

Housing and Urban Development Demonstration Program for the Chronically Mentally Ill

Project No.: 11-P-97952/4-04
Period: May 1981 - May 1985
Award: Grant
Grantee: Tennessee Department of Public Health
Bureau of Medicaid Administration and Coordination
283 Plus Park Boulevard
Nashville, Tenn. 37217

Community Alternatives to the Institutionalization of the Chronically Mentally Ill

Project No.: 11-P-98259/1-02
Period: March 1983 - March 1987
Award: Grant
Grantee: Connecticut Department of Income Maintenance
110 Bartholomew Avenue
Hartford, Conn. 06115

Cost-Effective Community Residential Treatment for the Mentally Ill

Project No.: 11-P-97787/1-04
Period: August 1981 - November 1986
Award: Grant
Grantee: Vermont Agency of Human Services
Department of Social Welfare
103 South Main Street
Waterbury, Vt. 05676

Highline Independent Apartment Living Project

Project No.: 11-P-98200/0-03
Period: April 1982 - April 1986
Award: Grant
Grantee: Department of Social and Health Services
Division of Medical Assistance, LK-11
Olympia, Wash. 98504

Quality

Improving New York State's Nursing Home Quality Assurance Program

Project No.:	11-P-97590/2-04
Period:	September 1980 - March 1986
Award:	Grant
Grantee:	State of New York Department of Social Services Tower Building Empire State Plaza Albany, N.Y. 12237
Project Officer:	Elizabeth S. Cornelius Division of Long-Term Care Experimentation

Description: This project tests the simplification of federally mandated periodic medical review/independent professional review processes in nursing homes, and combines the process with the annual facility survey. Surveyors use 11 sentinel health events (SHE), such as accidents, decubitus ulcers, and medication regimen to determine if nursing home patients are receiving quality care. Facilities found to have fewer than the average problems in these areas receive a less than full facility survey. This combined medical review and survey method reduces surveyors' time and allows State personnel to focus on facilities and patients with major problems.

Status: The project is currently in its fourth year. The new inspection-of-care processes are fully operational. The State has indicated that it is taking more legal actions than usual as a result of the new processes, but that fewer facilities are being cited for minor problems. During the fourth year, the project staff will continue to monitor the implementation of the new methods and integrate them with the new survey process. Also, the State will develop a detailed evaluation plan to test the validity of using these outcomes of care as an indicator of poor quality.

Quality Assurance Sampling: A Statistical Quality-Control Approach to Inspection of Care

Project No: 11-P-98260/1-02
Period: February 1983 - February 1986
Award: Grant
Grantee: Massachusetts Department of Public Welfare
600 Washington Street
Boston, Mass. 02111
Project Officer: Elizabeth S. Cornelius
Division of Long-Term Care Experimentation

Description: The main objective of the project is to verify that patients in nursing homes are receiving appropriate care at the appropriate level, without reviewing every patient. Current law requires a review of all Medicaid patients in a facility to verify the appropriateness of care and placement. This project will use statistical quality control techniques to achieve these goals so that surveyor time can be reallocated to other quality-assurance activities.

Status: Criteria have been developed for determining which facilities are appropriate for the sampling process. The procedures for sampling patients, including safeguards to control statistical biases, have been refined. Pretests of the process and orientation sessions for surveyors were conducted in July and August 1983. The project became operational on August 29, 1983. During the first quarter, more than 50 percent of the facilities received a 100-percent review based on the walk-through findings. During the last quarter of the first year and the first two quarters of the second year, only 25 percent of facilities have received a full review. This change is probably because of the learning process required to gain familiarity with the new procedures. During the second year of operation, the State will develop a detailed evaluation plan for the project and will enter into a contract with an independent evaluator.

Evaluation of Three-State Demonstration in Nursing Home Quality Assurance

Project No.: 500-82-0024
Period: August 1982 - September 1984
Funding: $ 662,113
Award: Contract
Contractor: Mathematics Policy Research
905 University Avenue
Room 203
Madison, Wis. 53715
Project Officer: Spike Duzor
Division of Health Systems and Special Studies

Description: This is an evaluation of a three-State demonstration testing new procedures for conducting nursing home facility surveys and patient quality-of-care determinations. The States participating in this demonstration include Wisconsin, New York, and Massachusetts. The Wisconsin inspection of care and survey demonstration was completed in September 1982. The Massachusetts survey-by-exception project was completed in December 1982. The New York demonstration is still active.

Status: A draft final report is currently being reviewed by the Health Care Financing Administration staff. The final report is expected by Summer 1985. The findings to date are favorable to the demonstration process. The independent evaluator recommends expanding efforts to utilize screening and resident sampling techniques during the survey and fully integrating the survey and inspection-of-care process.

Data Development and Analyses

Analysis of the 1982 Long-Term Care Survey

Funding: Intramural
Project Director: Candace Macken
Division of Program Studies

Description: The 1982 Long-Term Care Survey (LTCS) was designed to provide nationally representative data on the number and degree of physical impairments found among Medicare beneficiaries 65 years of age or over living in the community. Approximately 35,000 persons were first screened over the telephone to determine whether any of them had problems performing any of a series of activities of daily living (ADL's) or instrumental activities of daily living (IADL's) for a period of at least 3 months. Persons living in institutions were excluded from the Survey. Those who were determined to have limitations were then interviewed by personal visit and by a detailed questionnaire. Information was gathered on health conditions, ADL's, IADL's, helpers, cognitive functioning, social functioning, Medicare providers, health insurance, and income and assets.

Status: The Bureau of the Census completed data collection in October 1982. The analysis of the data and the development of reports are currently being carried out by researchers in the Health Care Financing Administration and the Office of the Assistant Secretary for Planning and Evaluation. These papers have been presented:

- "1982 Long-Term Care Survey: National Estimates of Functional Impairments Among the Elderly Living in the Community," presented at the National Association of Welfare Research and Statistics Conference in Hartford, Conn., August 1984.

- "1982 Long-Term Care Survey: Functional Impairments and Sources of Support of Elderly Medicare Beneficiaries Living in the Community," presented at the Gerontological Society of America Conference in San Antonio, Tex., November 1984.

The 1984 Long-Term Care Survey

Project No.:	IAA-84-P-383
Period:	October 1983 - September 1985
Funding:	$ 1.8 million
Award:	Interagency Agreement
Agency:	The Bureau of the Census Demographic Surveys Division Suitland, Md. 20233
Project Officer:	Candace Macken Division of Program Studies

Description: The 1984 Long-Term Care Survey (LTCS) capitalizes on the data collected for the 1982 Survey by interviewing the same persons, thus providing a longitudinal look at the functionally impaired elderly living in the community. The 1982 Survey has been expanded to provide a cross-sectional look at all functionally impaired Medicare beneficiaries 65 years of age or over no matter where they reside. The longitudinal component comprises all persons included in 1982 and still living in the community and all persons included in 1982 and now living in institutions and those who are deceased. The cross-sectional component comprises the longitudinal component and persons who were excluded in 1982 because they were institutionalized, a sample of person who did not screen into the 1982 Survey because they were not functionally impaired, and persons who have aged into the sample, that is persons who were 63 and 64 years of age in 1982 and who were 65 and 66 years of age in 1984. Persons were interviewed personally by using a detailed community questionnaire similar to the one used in 1982. Interviews were with a proxy for those who were institutionalized or deceased by using abbreviated questionnaires that collect information on services used and source of payment. Data for 1984 will make possible the analysis of circumstances leading to institutionalization and whether alternatives could have been considered. This would identify methods of intervention to forestall premature or inappropriate nursing home placements and thus reduce current estimates of national expenditures for nursing home services, particularly for the Medicaid program.

Status: The Bureau of the Census conducted field collection of data from June to October 1984. Data tapes are expected by the end of 1985.

National and Cross-National Study of Long-Term Care Populations

Project No.: 18-C-98641/4-01
Period: September 1984 - September 1985
Funding: $ 396,078
Award: Cooperative Agreement
Awardee: Duke University
Center for Demographic Studies
2117 Campus Drive
Durham, N.C. 27706
Project Officer: Candace Macken
Division of Program Studies

Description: The objective of this study is to assess the size, characteristics, and future growth of the elderly long-term care (LTC) population in the United States by using data from the 1982 and 1984 Long-Term Care Surveys. Multivariate analyses will be used to develop profiles of attributes that characterize distinct subgroups in the noninstitutionalized LTC population and to target individuals at risk of institutionalization. Comparative analyses will be performed using similar surveys from other countries.

Status: Preliminary analyses of the 1982 Survey have been completed for a 50-percent sample, using a grade-of-membership (GOM) model. This GOM model developed profiles of disability, medical conditions, and LTC service needs and utilization levels for persons in the sample.

Long-Term Care Residential Services for Developmentally Disabled People

Project No.: 18-P-98078/5-03
Period: September 1981 - June 1985
Funding: $ 1,166,635
Award: Grant
Grantee: University of Minnesota
207 Pattee Hall
150 Pillsbury Drive, S.E.
Minneapolis, Minn. 55455
Project Officer: Marni Hall
Division of Reimbursement and Economic Studies

Description: This project will update the only national information system on long-term care services for the mentally retarded and developmentally disabled (MR/DD). Data will be gathered on characteristics of residents and facilities, including intermediate care facilities for the mentally retarded (ICF-MR's). Data from this study will be used to track the effects of recent State deinstitutionalization policies. As part of the project, policy analyses of the cost/utilization of Medicaid MR/DD services are made. These analyses focus on: financing of residential care; case mix and movement of residents; and programs, services, and manpower.

Status: The project is scheduled to end March 31, 1985. National surveys of residential facilities and State statistical offices have been conducted and the data are currently being analyzed. Important policy analyses are underway, including longitudinal, descriptive analyses of the changes in the long-term care system for MR/DD people between 1977 and 1983, and analysis of Medicaid's changing role in the MR/DD area, including changes in the client population, the nature of ICF-MR's, and their costs. An analysis has been completed of 26 States' responses to Section 2176, Public Law 97-135, as it impacts on the MR/DD population. The findings indicated that:

- Almost 62 percent of the States studied planned to serve the MR/DD population under the Section 2176 waiver program.
- As a result of the waiver, 7 out of the 16 States with programs aimed at the MR/DD group felt that they would be able to reduce the number of institutional beds. In contrast, programs for the elderly under this waiver generally stressed diversion of new admissions rather than closing down beds.
- In general, most States planned to move the MR/DD population to less intensive types of long-term care facilities under this program. In most cases, the States did not foresee return to the client's home as a possibility.
- Case management was the service most often included in States' waiver requests. For the MR/DD group, rehabilitation services were the second most frequently requested service.
- Case-management systems were already in place and were better developed for the MR/DD population than for the elderly.
- Almost all of the States with MR/DD plans covered a large portion of the costs of services provided to recipients in residential care, although the costs of room and board were not allowable under the waiver.

A draft final report has been received. The final report for this project is due in July 1985.

National Academy of Sciences Panel on Statistics for an Aging Population

Project No.:	IAA-84-P432
Period:	December 1984 - December 1986
Funding:	$ 102,000
Award:	Interagency Agreement
Agency:	National Academy of Sciences Committee on National Statistics 2101 Constitution Avenue Washington, D.C. 20418
Project Officer:	Judith A. Kasper Division of Beneficiary Studies

Description: The purpose of this study is to examine the adequacy of current statistical information and methodology, particularly in the area of health and medical care, for an aging population. The study is being conducted through the Committee on National Statistics of the National Academy of Sciences/National Research Council, and is being supported by several Government agencies including Health Care Financing Administration, National Institute of Mental Health, National Institute on Aging, National Center for Health Statistics, and the Veterans' Administration. The study will determine:

- Whether the data that will be needed during the next decade for policy development for health care for an aging population are available.
- Whether available data are analyzed and used.
- Whether changes or refinements are needed in the statistical methodology used in both policy analysis and in the planning and administration of programs.

Status: Papers commissioned by a panel of experts will be presented at a conference in Fall 1985. A final report will be submitted to the sponsoring agencies at the end of the 2-year study in 1986.

AFDC Home Health Aides

AFDC Homemaker/Home Health Aide Demonstration

Period: January 1982 - June 1986
Project Officer: Dennis M. Nugent
Division of Long-Term Care Experimentation

Description: This 4-year demonstration is designed to study whether Aid to Families with Dependent Children (AFDC) recipients can be trained and employed to provide homemaker/home health aide services to elderly and/or disabled individuals who are at risk of institutionalization. The objectives of the demonstration are to reduce welfare dependency and to prevent or delay the institutional placement of any eligible service clients. This project will measure the costs and benefits of this type of program, including its contribution to the improvement in employment and earnings capacity of the AFDC recipient and the reduction in the need for institutional care of the functionally impaired, home-care service client.

Status: During January 1983, the seven States participating in this demonstration began the recruitment and selection of the AFDC recipients who had volunteered to take part in this project. Since that time, 2,216 welfare recipients have been trained as homemaker/home health aides. These aides have provided services to 5,496 clients who met the at-risk eligibility requirements. The demonstration is now in its final operational year. The final evaluation report is expected in July 1986.

A Plan for Employing AFDC Recipients as Homemaker/Home Health Aides to Provide Alternatives to Long-Term Care

Project No.: 12-P-98110/6-03
Award: Grant
Grantee: Arkansas Department of Human Services
P.O. Box 1437
Little Rock, Ark. 72203

Preventacare: An Alternative to Institutionalization

Project No.: 12-P-98111/4-03
Award: Grant
Grantee: Kentucky Cabinet for Human Resources
CHR Building, Sixth Floor West
275 East Main Street
Frankfort, Ky. 40621

AFDC Homemaker/Home Health Aide Demonstration Project

Project No.: 12-P-98113/2-03
Award: Grant
Grantee: New Jersey Department of Human Services
Capitol Place One
222 South Warren Street
Trenton, N.J. 08625

New York State AFDC Homemaker/Home Health Aide Demonstration

Project No.: 12-P-98103/2-03
Award: Grant
Grantee: New York State Department of Social Services
40 North Pearl Street, 7th Floor
Albany, N.Y. 12243

Employment Opportunities for AFDC Recipients in the Homemaker/Home Health Aide Field

Project No.: 12-P-98106/5-03
Award: Grant
Grantee: Ohio Department of Human Services
30 East Broad Street, 27st Floor
Columbus, Ohio 43215

Homemaker/Home Health Aide Project

Project No.: 12-P-98108/4-03
Award: Grant
Grantee: South Carolina Department of Social Services
P.O. Box 1520
Columbia, S.C. 29202

AFDC Recipients as Providers of Services to the Aged and Disabled

Project No.: 12-P-98104/6-03
Award: Grant
Grantee: Texas Department of Human Resources
522-A, P.O. Box 2960
Austin, Tex. 78769

Evaluation of the AFDC Homemaker/Home Health Aide Demonstration Project

Project No.: 500-82-0022
Period: June 1982 - June 1986
Funding: $ 454,174
Award: Contract
Contractor: Abt Associates, Inc.
55 Wheeler Street
Cambridge, Mass. 02138
Project Officer: Kathy Ellingson
Division of Long-Term Care Experimentation

Description: The purpose of this project is to evaluate the Aid to Families with Dependent Children (AFDC) Homemaker/Home Health Aide demonstration and to provide technical assistance to the seven States participating in the demonstration. The actual evaluation will occur under separate contracts with the seven participating States. A final report to HCFA will be based on the State evaluations. The three major evaluation objectives are to:

- Assess the costs and effectiveness of the training and employment of AFDC recipients as homemakers/home health aides on subsequent, continued, and nonsubsidized employment.

- Assess the costs and outcomes of providing home health aide services to persons at risk of institutionalization who would otherwise not receive these services.

- Assess the net cost effectiveness and provide policy-relevant projections on large-scale implementation.

Status: The contractor has completed five major deliverables: a data resources report; a report on issues in the design implementation; the final research design; and the first-year report, "Planning and Initial Implementation Experience." This report is a descriptive analysis of the seven States' first-year activity. Individual State case studies were also completed. The second-year annual report was completed in August 1984. The report summarizes the States' experiences in terms of their operational characteristics and the status and characteristics of the participants.

Other Long-Term Care

Bioactuarial Estimates and Forecasts of Health Care Needs and Disability

Project No.: 18-P-97710/4-03
Period: June 1980 - August 1984
Funding: $ 428,650
Award: Grant
Grantee: Duke University
2117 Campus Avenue
Durham, N.C. 27706
Project Officer: Paul W. Eggers
Division of Beneficiary Studies

Description: This project employs bioactuarial methods to estimate the need for various types of health services including long-term care. The determinations of levels of need are employed in analyses of the health status of small geographic areas as well as in national projections. The project is also examining how need estimates are being translated into utilization of nursing homes. These applications of bioactuarial strategies for forecasting population change in health status represent an extension of the grant's basic work.

Status: Results of this project include estimates and projections of the incidence and prevalence of specific chronic diseases (for example, cancer) among the elderly population. In addition, the study has provided new insights on the flow of the elderly population through the nursing home system (for example, admission rates and lengths of stay). Finally, the project is developing profiles of the elderly population in terms of the likelihood of their using alternative modes of long-term care. The National Medical Care Utilization and Expenditure Survey and the Long-Term Care Survey, both Health Care Financing Administration-funded efforts, have applied this methodology. Currently, 18 publications have been written under this grant:

- "Bioactuarial models of national mortality time series data: Strategies for making full information estimates of national morbidity distributions," Health Care Financing Review, Fall 1982.
- "The use of mortality time series data to produce hypothetical morbidity distributions and project mortality trends," Demography, Vol. 19, 1982.
- "Compartment model methods in estimating cancer costs," Approaches for Modeling Real World Problems a la H.O. Hartley Transaction of the Society of Actuaries, American Statistical Association, Cincinnati, Ohio, 1982.
- "The characteristics and utilization pattern of an admission cohort of nursing home patients," Gerontologist, Vol. 24/4, 1983.
- "Length of stay pattern of nursing home admissions," Medical Care, Vol. 21, 1983.
- "Compartment model methods in estimating costs of cancer," Transactions Society of Actuaries, 1983.

- "The characteristics and utilization pattern of an admissions cohort of nursing home patients II," Gerontologist, 1984.

- "Methods and issues in the projection of population health status," prepared for World Health Organization Division of Epidemiological Surveillance and Health Situation and Trend Assessment, World Health Statistics Quarterly, No. 3, 1984.

- "Projecting chronic disease prevalence," Medical Care, Vol. 22, 1984.

- "Strategies for collating diverse scientific evidence in the analysis of population health characteristics: Bioactuarial models of chronic disease mortality for the elderly," Sociological Methods and Research, Sage, Vol. 13, No. 3, 1984.

- "The economic impact of health policy interventions," Risk Analysis, Vol. 3, No. 4, 1983.

- "Life table methods for assessing the dynamics of nursing home utilization: 1976-1977," J. Gerontology, Vol. 39, 1984.

- "Morbidity, disability, and mortality: The aging connection," Aging 2000: Our Health Care Destiny, Vol. 2, Springer-Verlag, New York, 1985.

- "An analysis of the heterogeneity of U.S. nursing home patients," J. Gerontology, Vol. 40, 1985.

- "Dynamics of health changes in the extreme elderly: New perspectives and evidence," Special issue on the oldest old. Millbank Memorial Fund Quarterly, Vol. 63, No. 2, Spring, 1985.

- "The use of grade of membership analysis to evaluate and modify diagnosis-related groups," Medical Care, Vol. 22, No. 12, Dec. 1984.

- "Analytic approaches for determining incidence from prevalence and reported disease duration," Journal of the American Statistical Association, to be published.

Final year efforts are directed toward the development of explanatory models of stability and change among Supplemental Security Income recipients who became institutionalized in Medicaid certified facilities.

Comparison of the Cost and Quality of Home Health and Nursing Home Care

Project No.: 18-P-97712/8-04
Period: June 1980 - May 1985
Funding: $ 1,282,283
Award: Grant
Grantee: University of Colorado
4200 East 9th Avenue
Denver, Colo. 80262
Project Officer: Philip Cotterill
Division of Reimbursement and Economic Studies

Description: This study assesses the cost, quality, and cost effectiveness of nursing home and home health care provided by freestanding agencies and hospital-based facilities. Detailed data on patient conditions and services were collected for a sample of nursing home and home health patients from the following States: Arkansas, California, Colorado, Florida, Michigan, Minnesota, New York, Ohio, Pennsylvania, and Virginia. A subset of patients will be tracked over time to observe outcomes.

Status: During the third year, additional data on Medicare patients in skilled nursing facilities (SNF's) were collected so that case-mix comparisons could be made between Medicare and non-Medicare patients in hospital-based and freestanding facilities. The University of Colorado sampled 600 patients in high-volume Medicare SNF's in five States (California, Pennsylvania, Ohio, Michigan, and Texas), and 600 non-Medicare patients in hospital-based and freestanding nursing homes in 10 States (Arkansas, California, New York, Michigan, Minnesota, Colorado, Florida, Virginia, Pennsylvania, and Ohio). From these studies of case-mix differences, the following patterns emerge:

- Medicare patients are more seriously ill from a medical perspective and possess greater rehabilitation potential than other long-term care patients.

- Non-Medicare patients tend to be more dependent in functions, as measured by activities of daily living (ADL's), and have more traditional long-term care problems (e.g., impaired mobility, depression, and mental problems).

- In general, patients in hospital-based nursing homes tend to be more dependent in ADL's, have more traditional long-term care problems, and have more medically oriented problems than do patients in freestanding nursing homes.

More detailed results are presented in a report entitled, "Nursing Home Case-Mix Differences for Medicare Versus Non-Medicare and Hospital-Based Versus Freestanding Patients." In its fourth year the project will assess the cost effectiveness of nursing home and home health care for patients with the following problems: stroke, decubitus ulcers, congestive heart failure, urinary incontinence, and mental status problems.

Pursuit of Institutional Alternatives

Project No.: 18-P-98188/4-01
Period: December 1982 - October 1984
Funding: $ 242,478
Award: Grant
Grantee: North Carolina Health Care Facilities Association
5109 Bur Oak Circle
Raleigh, N.C. 27612
Project Officer: Marni Hall
Division of Reimbursement and Economic Studies

Description: This study explored the potential participation of North Carolina nursing homes in providing institutional alternatives to the elderly. Alternative programs which were examined include home health care, adult day care, and nutritional services. The legal, organizational, financial, and facility resource requirements for expansion were identified. This project also assessed the changes in demand for noninstitutional long-term care services, as a result of the Medicaid home- and community-based waivers authorized under Section 2176 of the Omnibus Budget Reconciliation Act of 1981, and conducted a preliminary evaluation of this waiver program in the State.

Status: More than 20 percent of the surveyed nursing home administrators indicated they would be initiating some new home or community services in 1985. The areas viewed as most attractive for expansion were outpatient provision of physical therapy, recreation therapy, nursing, and speech therapy. Physician support was seen as an important factor influencing the development of new services. Preliminary data from one county indicated that, thus far, the 2176 waiver program has had little impact on nursing home case mix.

Encouraging Appropriate Care for the Chronically Ill Elderly: A Controlled Experiment to Evaluate the Impacts of Incentive Payments on Nursing Home Admissions, Discharges, Case Mix, Care, Outcomes, and Costs

Project No.:	11-P-97931/9-04
Period:	April 1981 - June 1986
Award:	Grant
Grantee:	State of California Department of Health Services 714 P Street Sacramento, Calif. 95814
Project Officer:	Teresa Schoen Division of Long-Term Care Experimentation

Description: This project is testing a system of incentive payments as a means of encouraging skilled nursing facilities (SNF's) in San Diego to admit and provide quality care to severely dependent patients. Many patients have more lengthy hospital stays than appropriate because of the amount and cost of care these patients would require in an SNF. Health Care Financing Administration waivers permit SNF rates which exceed the Medicaid cost limits by the incentive amounts. Under the terms of the contracts with these SNF's, the incentive payments for patients admitted during the first project year will continue for up to 4 years from the date of admission (1986), if the patient remains in the facility. The National Center for Health Services Research (NCHSR) provides total project funding.

Status: The intake of patients ended April 30, 1982. Patient reassessments continued through April 30, 1983. Final compilation and editing of the data are now nearly completed. Final analysis of the study results are in progress. Waivers will end in 1986. As of November 30, 1984, the participating SNF's were receiving the admission incentive payments for 29 Medicaid patients under the demonstration. Preliminary results from the evaluation study are mixed. The proportion of Type E patient admissions (patients requiring special nursing, such as comatose care) to treatment group SNF's rose from 6.8 percent to 11 percent, and the proportion of Type E admissions to control group SNF's dropped slightly from 6.1 percent to 5.7 percent. Type D admissions (those dependent in all six activities of daily living) remained unchanged for both treatment and control groups. The NCHSR final evaluation report is projected for completion in early 1985.

Effects of Alternative Family Support Strategies

Project No.: 95-C-98281/0-02
Period: May 1983 - April 1986
Funding: $ 396,531
Award: Cooperative Agreement
Awardee: University of Washington
Long-Term Care Center
Institute on Aging
Seattle, Wash. 98195
Project Officer: Teresa Schoen
Division of Long-Term Care Experimentation

Description: The purpose of this project is to study the effects of support programs provided to families that care for their elderly members at home. The demonstration will assess the impact of three support strategies: paid respite care, family training and case management, and a combination of respite care with training and case management. The paid respite care includes services provided by a home health agency, an adult day-care center, and a skilled nursing facility. Key outcome variables to be measured are family burden, length of time families serve as primary caregivers, propensity toward institutionalization, and cost of long-term care services.

Status: By December 1983, the University had satisfied the terms and conditions of the Health Care Financing Administration's (HCFA) approval of this project. These conditions included clarification of the sampling design, development of a patient functional status screen, detailed description of the analysis plan, and agreement by the Medicaid State agency to request waivers which would permit participation by persons who are eligible for Medicaid only. HCFA approved the start of patient admissions to the project in January 1984. However, the University required additional time for startup tasks. These include signing memorandums of understanding with the three organizations providing paid respite care, developing a formal procedure for verifying Medicare beneficiary entitlement, developing notification letters to inform families about the covered project services, preparing an operations manual for providers, and hiring and training interviewers and the family coordinators who will provide the case-management services. Patient admissions to the project began in March 1984, and the paid respite services began in April. As of September 30, 1984, 384 patient/family units had been admitted to the project.

Analysis of Long-Term Care Payment Systems

Project No.: 18-C-98306/8-02
Period: April 1983 - June 1987
Funding: $ 1,358,011
Award: Cooperative Agreement
Awardee: Center for Health Services Research
University of Colorado
4200 East 9th Avenue
Denver, Colo. 80262
Project Officer: Judith Sangl
Division of Reimbursement and Economic Studies

Description: This project is a comparative analysis of long-term care reimbursement systems in seven States. The study will combine an empirical analysis of nursing home costs and payments and the determinants of costs with a detailed qualitative analysis of the operations of the reimbursement systems. The comparative analysis across States will be performed through a unique "comparison-by-substitution" method that calculates reimbursement for nursing homes in one State under the assumption that the other States' reimbursement systems are in effect. Data sources for this study include primary facility information and patient samples, as well as secondary sources such as cost reports.

Status: Major project activities are:

- Review of State nursing home reimbursement systems and selection of study States (Arkansas, Colorado, Florida, Maryland, Ohio, Utah, and West Virginia).
- Refinement of study research design.
- Development of patient-level data and facility-level collection instruments.
- Design, screening, and recruitment of nursing home facility sample.

Four reports have been prepared:

- "Case-Mix Measures and Medicaid Nursing Home Payment-Rate Determination in West Virginia, Ohio, and Maryland."
- "Overview of Medicaid Nursing Home Reimbursement Systems."
- "Case-Mix and Capital Innovations in Nursing Home Reimbursement."
- "An Analysis of Long-Term Care Payment Systems: Research Design."

Long-Term Care of Aged Individuals With Hip Fractures: Public Versus Private Costs

Project No.: 18-C-98393/3-02
Period: September 1983 - September 1986
Funding: $ 537,678
Award: Cooperative Agreement
Awardee: University of Maryland Medical School
655 West Baltimore Street
Baltimore, Md. 21201
Project Officer: Judith Sangl
Division of Reimbursement and Economic Studies

Description: This study is examining, in detail, the complex economic and psychosocial determinants of the public and private contribution to the long-term care of a group of aged individuals who suddenly become disabled by hip fractures. The impact of family size and composition, social support, family economic resources, and the aged individual's physical and mental health will be analyzed in terms of the decision to enter a nursing home or return home.

Status: Selected for the study were seven Baltimore area hospitals. Survey instruments (baseline and followup) for the patient and the "significiant other" have been designed and pretested. Interviewing has begun.

Responsibility of Children for Financing Institutional Care: Potential Response and Possible Adjustments

Project No.: 18-C-98375/1-02
Period: November 1983 - May 1985
Funding: $ 80,000
Award: Cooperative Agreement
Awardee: Hebrew Rehabilitation Center for the Aged
1200 Centre Street
Boston, Mass. 02131
Project Officer: Judith Sangl
Division of Reimbursement and Economic Studies

Description: The objective of this project is to determine the barriers to and potential for alternate payment schemes for long-term care, particularly nursing home care, by the children of the elderly. The research will:

- Provide an estimate of children's resources available to share in the costs of long-term care.
- Assess the attitudes of those children toward proposals for sharing in the costs of their parents' long-term care and identify factors associated with those who have positive and negative feelings.
- Assess the market for a new type of insurance for nursing home care, and identify factors associated with those who are and are not interested in such insurance.

Status: Interviewing was completed in December 1984, and data analysis has begun.

Can Geriatric Nurse Practitioners Improve Nursing Home Care?

Project No.: 18-C-98379/9-02
Period: September 1983 - December 1986
Funding: $ 573,760
Award: Cooperative Agreement
Awardee: The Rand Corporation
1700 Main Street
Santa Monica, Calif. 90406
Project Officer: Judith Sangl
Division of Reimbursement and Economic Studies

Description: The purpose of the study is to evaluate the potential of the use of geriatric nurse practitioners (GNP) for improving outcomes of care and containing costs in skilled nursing facilities. The 30 nursing homes that participated in the Mountain States Health Corporation's GNP demonstration project will be compared with 30 nursing homes in the region that did not participate. Comparisons will be made of:

- Patient outcomes.
- Process of care.
- Nursing home costs.
- History of certification deficiencies.

Homes will be matched by State, ownership, bed size, and urban, suburban, or rural location.

Status: The project has recruited sites and data collectors, developed and pilot-tested instruments, conducted training sessions for data collectors, and met with the Advisory Committee. The major patient-level data collection activities are underway.

Case-Managed Medical Care for Nursing Home Patients

Project No.: 95-P-98346/1-02
Period: July 1983 - July 1986
Award: Grant
Grantee: Massachusetts Department of Public Welfare
600 Washington Street
Boston, Mass. 02111
Project Officer: Jean L. Bainter
Division of Long-Term Care Experimentation

Description: The Health Care Financing Administration granted Medicare and Medicaid waivers to the Massachusetts Department of Public Welfare to permit fee-for-service reimbursement for the provision of medical services by physician-supervised nurse practitioners/physician assistants for 6,500 residents of nursing homes. This will permit increased medical monitoring that is expected to generate cost savings as a result of fewer hospital admissions and hospital outpatient visits. The evaluation will examine the effects of the program on expenditures, the quality of care, and the cost implications of carrying out the program on a large scale.

Status: The first year of this project was a developmental phase, which included marketing the concept to other providers (individual physicians and groups) and to nursing home administrators. During the second year, eight additional providers joined the project. This will increase the number of recipients of service by approximately 3,000 persons. An evaluation of this project by an outside contractor is planned.

Study of Long-Term Care Quality and Reimbursement in Teaching and Nonteaching Nursing Homes

Project No.: 18-C-98417/8-02
Period: September 1983 - September 1986
Award: Cooperative Agreement
Funding: $ 806,952
Awardee: University of Colorado Health Sciences Center
4200 East 9th Avenue, C-421
Denver, Colo. 80262
Project Officer: Kathy Ellingson
Division of Long-Term Care Experimentation

Description: This study evaluates the Teaching Nursing Home Program (TNHP) sponsored by the Robert Wood Johnson Foundation. The purpose of the TNHP is to improve the health care provided to long-term care patients. Each of 11 university-based schools of nursing were funded to establish clinical affiliations with one or two nursing homes. This study evaluates the impact of the affiliations on patient outcomes and costs of patient care. Specifically, the study will assess the extent the TNHP approach reduces hospitalizations and emergency room care; decreases length of nursing home stays and increases discharge into independent living environments; and enhances health status. A net cost-benefit ratio will be determined.

Status: Refinement of the study design, selection of comparison nursing homes, and development of primary data collection instruments were the main activities during the first year. A programmatic analysis providing an indepth look at how the TNHP is implemented in different facilities was completed in October 1984.

Prevention of Falls in the Elderly

Project No.:	95-C-98578/9-01
Period:	September 1984 - September 1987
Funding:	$ 375,000
Award:	Cooperative Agreement
Awardee:	Kaiser Foundation Research Institute Health Services Research Center 4610 Southeast Belmont Street Portland, Oreg. 97215
Project Officer:	Leslie N. Saber Division of Long-Term Care Experimentation

Description: In September 1984, a cooperative agreement was awarded to the Kaiser Foundation Research Institute to test the cost effectiveness of different approaches to the prevention of falls in the elderly. The project will be conducted at the Health Services Research Center, Kaiser Permanente Medical Care Program, in Portland, Oreg. Kaiser will conduct a 3-year randomized trial of 1,000 elderly beneficiaries who will participate in one of three intervention groups and a control group. After an initial assessment visit, one group will be offered minor home renovations and the installation of safety equipment; a second group, the behaviorial change group, will be offered a self-management educational curriculum; and the third group will be offered both the safety equipment and the curriculum. The project period will be 3 years with data collection for a 24-month period on all participants. Funding support for this demonstration will be supplemented by the National Institute on Aging and private foundations.

Status: An interagency agreement with the National Institute on Aging has been signed by the Director of the Institute, and it is currently undergoing internal clearances by the Health Care Financing Administration before it is officially approved and signed. The project has initiated preliminary planning and development activities.

Massachusetts Health Care Panel Study of Elderly--Wave IV

Project No.: 18-C-98592/1-01
Period: July 1984 - January 1986
Funding: $ 150,000
Award: Cooperative Agreement
Awardee: Harvard University/Harvard Medical School
1350 Massachusetts Avenue
Holyoke Center 458
Cambridge, Mass. 02138
Project Officer: Marni Hall
Division of Reimbursement and Economic Studies

Description: This project will collect the fourth wave of self-reported information from the Massachusetts Health Care Panel Study cohort, a group that was selected 10 years ago as a statewide probability sample of all persons 65 years of age or over. The data from the first three waves were analyzed and the results have been reported in numerous articles in professional journals. In this project, the data from all four waves will be analyzed to determine markers of functional decline during pre-death, predictors of long-term care institutionalization, and interrelationships between physical, behavioral, and social characteristics and subsequent health care and social service utilization and mortality.

Status: Thus far, efforts in this project have been concentrated on updating the Wave IV sample and developing the Wave IV questionnaire.

Quality of Life Among Life-Care Facility and Community Residents: A Comparison

Project No.: 18-C-98630/4-01
Period: November 1984 - November 1985
Funding: $ 28,539
Award: Cooperative Agreement
Awardee: Duke University Medical Center
Center for the Study of Aging and Human Development
Box 3003
Durham, N.C. 27710
Project Officer: Judith Sangl
Division of Reimbursement and Economic Studies

Description: The objective of this project is to determine whether living in a life-care facility (where, typically, life-long care is assured and services are accessible) has an impact on residents' quality of life (defined in terms of functional status), that make it significantly different from that of community residents, and whether the services used and the cost of maintaining or attaining a particular functional status is the same for life-care residents as for matched community residents. The study will use longitudinal data collected from a life-care facility in North Carolina and from the General Accounting Office survey of elderly people in Cleveland, Ohio.

Status: This project began in December 1984, and is in its early developmental stage.

Long-Term Care Client Targeting Manual

Project No.: 500-84-0062
Period: October 1984 - April 1985
Funding: $ 25,000
Award: Contract
Contractor: Berkley Planning Associates
3200 Adeline Street
Berkley, Calif. 94703
Project Officer: David Schwartz
Health Services Studies Office

Description: This project is authorized under the Small Business Innovation Development Act of 1982 (Public Law 97-219). The project allows Berkley Planning Associates (BPA) to develop a detailed outline and product testing plan for a long-term care client-targeting manual. During the initial phase, the study team will redefine findings from their study into forms and examples that can facilitate agency decisions regarding acceptance of clients and determination of their needs. This stage will also include the selection of a user population and the development of a comprehensive plan for field testing.

Status: The work to be performed is in the design or early developmental stages.

A Voucher Insurance Plan to Mobilize Volunteer Support Among the Elderly

Project No.: 500-84-0064
Period: October 1984 - April 1985
Funding: $ 25,673
Award: Contract
Contractor: Berkley Planning Associates
3200 Adeline Street
Berkley, Calif. 94703
Project Officer: David Schwartz
Health Services Studies Office

Description: This project is authorized under the Small Business Innovation Development Act of 1982 (Public Law 97-219). The project is to develop a voucher insurance plan to mobilize voluntary support services among elderly Medicare beneficiaries. An individual would earn a voucher by providing volunteer services for other elderly individuals. These vouchers could then be redeemed when an individual becomes ill and requires assistance. A coordinator would handle the vouchers and the dispatching of volunteers.

Status: The work to be performed is in the design or early developmental stages. The project appears to be progressing smoothly and the only problem to date has been translating pertinent documentation and questionnaires from English to Spanish.

Comparison by State of SNF/ICF Types: Beds, Staffing, Utilization, and Ownership

Funding: Intramural
Project Director: Elizabeth S. Cornelius
Division of Long-Term Care Experimentation

Description: This project unduplicated the count of skilled nursing facilities (SNF's), intermediate care facilities (ICF's), and their respective beds for 1981. The facility and bed count are based on the Medicare/Medicaid Automated Certification System (MMACS) data as of May 31, 1981. Full-time equivalents for registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, pharmacists, qualified social workers, and dietitians have also been identified. A staffing matrix showing the relationship to current staffing regulations was developed. In addition, a staffing matrix, using number of beds to nurse staffing ratios, will be tested. This project is being conducted in conjunction with a project funded by the Office of the Assistant Secretary for Planning and Evaluation (ASPE), Department of Health and Human Services, which evaluated the usefulness of the MMACS system for research and policy-analysis purposes. The intramural analysis will examine State-by-State differences in:

- Types of certified, long-term care facilities (SNF only, SNF/ICF combination, and ICF only).
- Certified bed supply in relation to the population and total long-term care bed supply.
- Professional staffing levels.

The analysis will also identify the percent of total certified beds used by Medicare, Medicaid SNF, and Medicaid ICF, during fiscal year 1981. A 1984 update, unduplicating the file and matching it to 1981, has been approved so that bed supply and staffing can be compared for a 3-year period.

Status: The ASPE evaluation has been completed, and the final report has been accepted by the Department. The evaluation found that the staffing data are acceptable for a State-level analysis. An unduplicated tape has been prepared and tables have been constructed. The staffing data have been cross checked with the Master Facility Inventory File maintained by the National Center for Health Statistics, and a research file at Columbia University. A comparison of the bed data has been made with the 1980 and 1982 Master Facility Inventory. The data matches and thus enables a comparison of total long-term care beds to certified beds. The unduplicated file is being used by several grantees and contractors relative to nursing home supply and demand studies. By 1986, changes in the entry process to the MMACS Master File are scheduled to be completed, and ongoing data comparisons will be made.

Competition

A Demonstration of Cost Control and Patient Satisfaction Resulting from the Relaxation of the Maximum Public Enrollment Rule for HMO's

Project No.: 11-P-97986/5-03
Period: April 1981 - March 1985
Award: Grant
Grantee: Michigan Department of Social Services
300 South Capitol Avenue
P.O. Box 30037
Lansing, Mich. 48909
Project Officer: Eric R. Nevins
Division of Health Systems and Special Studies

Description: The purpose of this demonstration is to test the effects on the cost and quality of care in health maintenance organizations (HMO's) resulting from the relaxation of the regulation requiring that Medicare and Medicaid beneficiaries cannot exceed 75 percent of total HMO enrollment. The project will compare the quality of care provided in HMO's exceeding the limit with HMO's conforming to the regulation through the use of satisfaction surveys.

Status: The survey questionnaire measures patient satisfaction in relation to seven health care dimensions, in addition to demographics and health care expenses. The project has been extended through March 31, 1985. At that time, Comprehensive Health Services of Detroit will contract through the regular Medicaid program under Section 2364 of the Deficit Reduction Act of 1984.

Test of the Out-of-Pocket Cost Savings as an Incentive for Changing Beneficiary Choice Behavior

Project No.: 17-C-98392/3-02
Period: September 1983 - September 1986
Funding: $ 709,316
Award: Cooperative Agreement
Awardee: Morgan State University
Institute for Urban Research
Baltimore, Md. 21239
Project Officer: Benson Dutton
Division of Reimbursement and Economic Studies

Description: The project is designed to develop basic knowledge on how elderly health care consumers obtain and process information, and how they balance various factors when making decisions under Medicare. The project has four objectives:

- To investigate ways of making beneficiaries more cost conscious.
- To examine the impact of information on expected out-of-pocket costs on beneficiary choice and behavior.
- To devise optimal approaches for beneficiaries to use in approaching their providers.
- To train beneficiaries in these techniques and test their effect.

Status: The grantee has refined the research design, formalized subcontract relationships, and begun the identification and collection of background data.

American Association of Retired Persons' Informed Buyer Program

Project No.: 18-P-98391/3-01
Period: September 1983 - December 1985
Funding: $ 256,080
Award: Grant
Grantee: American Association of Retired Persons
P.O. Box 19269
Washington, D.C. 20036
Project Officer: Kathleen Farrell
Division of Health Systems and Special Studies

Description: This demonstration project is designed to sensitize health maintenance organizations (HMO's) to offer an improved benefit package for the Medicare-eligible population. This will be accomplished in five sites by educating and training older volunteer health advocates about the HMO option and by assisting these advocates in persuading the HMO's to offer a benefit package attractive to Medicare beneficiaries. In addition, a community-wide education program will be implemented to inform Medicare beneficiaries about the HMO option and how to compare it with other health care options, and to encourage them to review their current coverage in light of this new information.

Status: The following sites have been selected: San Francisco/Oakland, Calif.; Bridgeport, Conn.; Tampa, Fla.; Detroit, Mich.; and Philadelphia, Pa. Volunteer coordinators have been recruited and trained in each site and are conducting educational programs on the HMO option. Using volunteers to advocate an enriched Medicare benefit package in HMO's was delayed until the second year of operation when the Tax Equity and Fiscal Responsibility Act of 1982 regulations were implemented.

Competitive Bidding for Clinical Laboratory Services

Project No.: 500-82-0054
Period: September 1982 - March 1984
Funding: $ 188,979
Award: Contract
Contractor: Center for Health Policy Studies
5865 Robert Oliver Place
Columbia, Md. 21045
Project Officer: Diane L. Rogler
Division of Hospital Experimentation

Description: The purpose of this 18-month contract was to develop the materials necessary for Medicare to test the use of competitive bidding for the purchase of non-inpatient laboratory services. The contract involved a mini-market study to collect and evaluate information about the laboratory industry from three sites, followed by a series of papers addressing the various issues which are important to the design of a bidding system. These include monopoly concerns, freedom of choice, which laboratory services are appropriate for bidding, how the bidding system could be administered, and which patient populations should be involved.

Status: The Center for Health Policy Studies submitted the final report for this project. The final report includes: a comprehensive description of the bidding systems, an implementation strategy, the draft documents to be used in soliciting bids, and evaluation issues/data report and copies of the various developmental reports written under this contract. The final report is available through the National Technical Information Service, Accession no. PB84-241520.

End-Stage Renal Disease Competitive Bidding Demonstration

Funding: Intramural
Project Directors: Thomas A. Noplock and Melvin Bulkley
Division of Hospital Experimentation and
Division of Health Systems and Special Studies

Description: The Health Care Financing Administration (HCFA) is planning to implement a competitive bidding demonstration for end-stage renal disease (ESRD) maintenance dialysis services in two site locations. The project would involve each independent and hospital-based provider of outpatient maintenance dialysis services in the areas. Each facility would be asked to submit a bid for providing maintenance dialysis services to Medicare beneficiaries, not to exceed the Medicare composite rate for independent facilities. The approved competitive bid rate will serve as the basis of Medicare reimbursement to the facility. Beneficiaries will be eligible to receive a cash incentive payment equal to 70 percent of the difference between the composite rate for independent facilities and the bid rate of the facility. If a facility does not submit a bid, or submits a bid higher than the composite rate, the facility will continue to receive its normal composite rate payment and the beneficiary may elect to receive care at that facility or change to a facility participating in the demonstration. The demonstration will test whether the potential for increased case loads will induce facilities to bid lower prices and whether the availability of cash incentives will induce beneficiaries to seek lower-priced facilities.

Status: The metropolitan statistical areas of Riverside, Calif., and Denver, Colo., have been selected as site locations. The California Department of Health Services and the Colorado Department of Social Services have both requested the appropriate Medicaid statewide eligibility waivers for approval by the Health Care Financing Administration. Implementation of the demonstration will begin in Spring 1985. The Urban Institute has submitted detailed plans for the evaluation of the demonstration and has begun collection of baseline data.

Design of a Demonstration and Assessment of Competitive Health Insurance Proposals in the End-Stage Renal Disease Program

Project No.: 14-P-98275/3-01
Period: April 1983 - March 1986
Funding: $ 879,694
Award: Grant
Grantee: The Urban Institute
2100 M Street, N.W.
Washington, D.C. 20037
Project Officer: Mel Bulkley
Division of Health Systems and Special Studies

Description: This project will determine the feasibility of demonstrations to test competitive financing approaches in the end-stage renal disease (ESRD) program, with possibilities including:

- Competitive bidding.
- Global capitation covering all medical care costs.
- Partial capitation covering only outpatient ESRD services.
- Voucher payment allowing patients to share in the financial savings of cost-reducing shifts.

If competitive approaches are feasible, the Urban Institute will develop the demonstration model and an evaluation design. The evaluation will consider:

- Structure of the experimental treatments.
- Methods to ensure randomization.
- Determination of appropriate capitation amounts.
- Design of a reinsurance system.
- Estimate of sample sizes.

Status: The grantee is assisting the Health Care Financing Administration in the development of its intramural end-stage renal disease competitive bidding demonstration. It has submitted a detailed plan for the evaluation of that demonstration. Urban Institute is collecting baseline data and will analyze the data relating to case-mix, quality, and patient-choice factors. Preliminary reports have been submitted on the competitive bidding models. These reports provide the conceptual background and consider practical implementation issues of the various bidding models.

Captitation Payment System for All End-Stage Renal Disease Services

Project No.: 95-C-98497/9-01
Period: January 1985 - December 1989
Funding: $ 380,000
Award: Cooperative Agreement
Awardee: El Camino Hospital District Corporation
2500 Grant Road
Mountain View, Calif. 94042
Project: Marla Aron
Officer: Division of Health Systems and Special Studies

Description: This project will develop and test a competitive capitation program under which capitation payments would cover all Medicare benefits to end-stage renal disease (ESRD) patients (including transplants). The awardee will negotiate a capitation rate with the Health Care Financing Administration (HCFA) at 95 percent of the estimated Medicare fee-for-service cost. A delivery system similar to a health maintenance organization will be developed and will include case management for ESRD patients, patient incentives, physicians' incentives and risk taking, preferred provider contracts, and quality assurance measures.

Status: The awardee is preparing to negotiate capitation rate and stop-loss provisions with HCFA.

Health Care Alternatives Within Title XIX: Evaluation of Alternative Reimbursement Methods to Providers of Primary Care Medical Services

Project No.: 11-C-98321/5
Period: April 1983 - March 1986
Funding: $ 585,675
Award: Cooperative Agreement
Awardee: Michigan Department of Social Services
300 South Capitol Avenue
Lansing, Mich. 48909
Project Officer: Gerald S. Adler
Division of Beneficiary Studies

Description: The study will examine the consequences of enrollment in innovative medical care organizations for the cost, effectiveness, quality, and accessibility of medical care provided to Medicaid populations in Michigan. The organizational types to be compared are:

- Health maintenance organizations (HMO's).
- Capitated ambulatory plans (CAP's) that do not cover inpatient, dental, long-term care, or personal care.
- Physician's primary sponsor plans (PPSP's) that feature case management, although care is paid for on a fee-for-service basis.

These organizations form a continuum of provider risk, and they are to be compared with standard fee-for-service care.

Status: A sample of 20,000 Medicaid recipients in Wayne County, Mich., has been drawn, with 10,000 randomly assigned to the PPSP and 10,000 to the comparison group. Enrollment in the PPSP program has grown more slowly than expected. Preenrollment studies of patient satisfaction and physician attitudes have been conducted. Data collection for the study period is underway.

Medicare Prospective Capitation Demonstration Project

Project No.:	95-P-98147/4-03
Period:	April 1982 - March 1985
Award:	Grant
Grantee:	International Medical Centers, Inc. 1505 167th Street, N.W. Miami, Fla. 33169
Project Officer:	John Sirmon Division of Health Systems and Special Studies

Description: This project will demonstrate and test an alternative to traditional Medicare financing and health care delivery in South Florida. The health maintenance organization (HMO) will provide covered Medicare benefits for an amount of reimbursement equal to 95 percent of the adjusted average per capita cost. Extra benefits are being offered to Medicare beneficiaries at little or no cost, including dental benefits, eyeglasses, hearing aids, prescription drugs, and transportation to the HMO. The project's service area includes: Dade, Broward, Palm Beach, Hillsborough, Pasco, and Pinellas Counties.

Status: Preparation for implementation of the demonstration proceeded from April through July 1982. On August 1, 1982, more than 10,000 Medicare beneficiaries were enrolled in the demonstration. These beneficiaries were already enrolled in a Health Care Financing Administration sponsored Section 1876 risk contract. Since that time, International Medical Centers (IMC) has averaged more than 2,000 new members per month. IMC currently serves approximately 164,000 members, 118,000 (72 percent) of which are Medicare beneficiaries under the demonstration program. IMC's delivery system includes a hospital and nine outpatient health centers owned and operated by IMC; and an additional 131 medical centers/health centers under contract with IMC to provide services. The demonstration ended on March 31, 1985, and the plan will continue serving Medicare beneficiaries under the Tax Equity and Fiscal Responsibility Act of 1982 requirements.

Enrollment of Medicare Beneficiaries Under a Unique Intra-Health Maintenance Organization Competition Model

Project No.: 95-P-98215/4-03
Period: September 1982 - March 1985
Award: Grant
Grantee: Comprehensive American Care
Health Plan, Inc.
P.O. Box 013140
Miami, Fla. 33101
Project Officer: Kathleen Farrell
Division of Health Systems and Special Studies

Description: This project will demonstrate and test an alternative to traditional Medicare financing and health care delivery in Miami. The health maintenance organization (HMO) will provide covered Medicare benefits and several extra benefits for an amount of reimbursement equal to 95 percent of the adjusted average per capita cost. A unique feature of the HMO is an enrollee privilege to seek out-of-plan physician services subject to a deductible and copay amount.

Status: The first enrollees in Comprehensive American Care became effective October 1, 1982. There are 6,535 Medicare enrollees in the plan. The plan offers extensive benefits in addition to Medicare, with no monthly premium in Dade and Broward Counties. The demonstration ended on March 31, 1985, and the plan will continue serving Medicare beneficiaries under the Tax Equity and Fiscal Responsibility Act of 1982 requirements.

Waiver-Only Competition Project for Southern California, Illinois, Indiana, and Texas

Project No.: 95-P-98342/9-02
Period: June 1983 - June 1985
Award: Grant
Grantee: Maxicare Health Plans, Inc.
11633 Hawthorne Boulevard
Hawthorne, Calif. 90250
Project Officer: Shelagh Smith
Division of Health Systems and Special Studies

Description: Maxicare Health Plans, Inc. is a for-profit, federally qualified, independent physicians' association model, health maintenance organization based in Hawthorne, Calif., serving seven counties in Southern California as well as areas around Chicago, Ill. Two sites will be phased in over a 1-year period. Maxicare plans to evaluate enrollment/disenrollment, utilization, cost, and quality. They will accept 95 percent of the adjusted average per capita cost.

Status: Maxicare began enrolling Medicare beneficiaries under this prospective capitation in Chicago in December 1984. Maxicare intends to enroll beneficiaries in the Los Angeles site in June 1985. A final protocol was approved April 1984. Maxicare offers two benefit packages, with the low option at no premium and the high option at $30.00 per month. The high option differs from the low option primarily by the addition of vision screening and drugs. No deductible and some copayments will be charged for services. Current enrollment in the Chicago site is 5,200 Medicare beneficiaries. When the demonstration period ends, continuation will depend on compliance with the Tax Equity and Fiscal Responsibility Act of 1982 requirements.

Medicare Competition Demonstration

Project No.: 95-P-98445/5-02
Period: September 1983 - June 1985
Award: Grant
Grantee: Share Development Corporation
3600 West 80th Street
Bloomington, Minn. 55431
Project Officer: Ronald Deacon
Division of Health Systems and Special Studies

Description: The purpose of this project is to replicate the Share Medicare experience of Minneapolis/St. Paul in Chicago. Share-Illinois is a hospital-based, individual practice association model, health maintenance organization with several group model components. The protocol design phase was completed in Spring 1984 and operations commenced in July. Share is being reimbursed 95 percent of the adjusted average per capita cost and is offering, in addition to all Medicare Part A and Part B benefits, an expanded benefit package including: unlimited hospital inpatient care; 365 days of skilled nursing facility care; and routine physical, eye, hearing, and foot examinations. The monthly premium is $19.75 and there are token copays for emergency/urgently needed services and mental health services.

Status: Medicare beneficiary enrollment began in July 1984. Current enrollment is 8,600 and Share-Illinois anticipates a total first-year enrollment of 10,000 beneficiaries. When the demonstration period ends, continuation will depend on compliance with the Tax Equity and Fiscal Responsibility Act of 1982 requirements.

Medicare Competition Demonstration

Project No.: 500-82-0037
Period: September 1982 - March 1985
Award: Contract
Contractor: Av-Med, Inc.
9400 S. Dadeland Boulevard
Miami, Fla. 33156
Project Officer: Kathleen Farrell
Division of Health Systems and Special Studies

Description: This project will test alternatives to traditional Medicare financing and delivery of health services in Miami. Av-Med is a federally qualified, individual practice association model, health maintenance organization (HMO) that has a contract to implement a full-risk prepaid capitation demonstration project in Dade and Broward Counties, Fla. Av-Med is accepting 95 percent of the adjusted average per capita cost and is providing an expanded benefit package with no monthly premium. Av-Med has more than 100 independent practice physicians participating in the demonstration. The HMO intends to enroll at least 5,000 Medicare beneficiaries during each year of the demonstration.

Status: Av-Med began Medicare demonstration enrollment on November 1, 1982. Av-Med expanded to Tampa (counties of Hillsborough, Manatee, Pasco, and Pinellas) and north to Palm Beach County in January 1984. Currently, Av-Med has a total of 11,077 Medicare beneficiaries enrolled. The demonstration ended March 31, 1985, and the plan will continue serving Medicare beneficiaries under the Tax Equity and Fiscal Responsibility Act of 1982.

Medicare Competition Demonstration

Project No.:	500-82-0050
Period:	September 1982 - March 1985
Funding:	$ 363,524
Award:	Contract
Contractor:	Family Health Program, Inc. 9930 Talbert Avenue Fountain Valley, Calif. 92708
Project Officer:	Eric R. Nevins Division of Health Systems and Special Studies

Description: This is a project designed to develop and test an alternative model for financing and delivering health care services to Medicare beneficiaries living in southern Los Angeles County and Orange County, Calif. Family Health Program (FHP) is a federally qualified, health maintenance organization (HMO) which proposed to compete for area beneficiaries by making available an attractive benefit package. FHP plans to demonstrate that a clinical facility, designed specifically for a Medicare population, will improve quality of care and is cost effective. Reimbursement will be based on 95 percent of the adjusted average per capita cost.

Status: FHP has enrolled approximately 21,000 Medicare beneficiaries since marketing activities began in September 1983. This demonstration is unique in that FHP has constructed a multiservice health care center designed specifically for Medicare beneficiaries. FHP offers two options to beneficiaries--a basic and extended benefit package. The basic plan, which has no monthly premium requirements, covers all Medicare benefits plus preventive services and prescriptions with small copayments. The extended package, offered for a $35 monthly premium, also covers refractions, eyeglasses, podiatry, and dental care and eliminates copayments for basic services. Of the enrollees, 15 percent selected the high option. The demonstration ended on March 31, 1985, and the plan will continue serving Medicare beneficiaries under the Tax Equity and Fiscal Responsibility Act of 1982.

Medicare Competition Demonstration

Project No.: 500-82-0043
Period: September 1982 - March 1985
Award: Contract
Contractor: Watts Health Foundation
10300 Compton Avenue
Los Angeles, Calif. 90002
Project Officer: Eric R. Nevins
Division of Health Systems and Special Studies

Description: This is a project designed to test an alternative model for enhancing competition among providers of care. Watts Health Foundation United Health Plan (UHP) will implement a competitive demonstration through a contract with the Health Care Financing Administration (HCFA) to provide Medicare beneficiaries in the Los Angeles-Orange County area with a comprehensive set of benefits covering physician services, hospitalization, and other medical services. Reimbursement for services will be prospectively determined on a capitation basis. UHP will also provide all administrative, marketing, quality assurance, and utilization control functions required under this contract.

Status: UHP has signed a contract and has been granted waivers by HCFA for the operation of a Medicare competition demonstration project in the Los Angeles area. The waivers permit prospective reimbursement and the delivery of additional benefits offered to Medicare beneficiaries. Watts receives reimbursement at 95 percent of what Medicare would normally pay in the fee-for-service system. The project began delivery of services in April 1984. UHP has increased their enrollment because they have eliminated the premium for the basic option. Enrollment now stands at 4,750 beneficiaries. Approximately 500 of these enrollees are crossover Medicare/Medicaid beneficiaries. Traditionally, those who have been served by the UHP are the categorically eligible for Medicaid. The mixing of public beneficiaries from Medicaid and Medicare in a largely publicly funded HMO provides a unique aspect for this demonstration. The demonstration ended on March 31, 1985, and the plan will continue serving Medicare beneficiaries under the Tax Equity and Fiscal Responsibility Act of 1982.

Medicare Competition Demonstration

Project No.: 500-82-0049
Period: September 1982 - November 1984
Funding: $ 232,835
Award: Contract
Contractor: Blue Cross of California
P.O. Box 70000
Van Nuys, Calif. 91409
Project Officer: Nancy Row
Division of Health Systems and Special Studies

Description: This project was designed to test alternatives to traditional Medicare financing and delivery of health services in the Santa Barbara area. Reimbursement will be on a prepaid per capita basis, capitated at 95 percent of the adjusted average per capita cost. Financing will be on a risk basis. Two alternatives will be tested including a preferred provider arrangement. Each alternative will offer a high and low option.

Status: Blue Cross of California was notified in November 1984 that the preferred provider organizations could be eligible for contracting with the Health Care Financing Administration as a competitive medical plan under the Tax Equity and Fiscal Responsibility Act of 1982. Therefore, the demonstration contract was terminated for the convenience of the Government.

Medicare Competition Demonstration

Project No.: 500-82-0051
Period: September 1982 - September 1987
Funding: $ 980,646
Award: Contract
Contractor: Health Choice, Inc.
621 S.W. Alder Street
Suite 820
Portland, Oreg. 97205
Project Officer: Nancy Row
Division of Health Systems and Special Studies

Description: This project will test the viability of an independent broker for Medicare beneficiaries in an area (Portland, Oregon) with multiple health plans. Reimbursement will be on a prepaid per capita basis, capitated at 95 percent of the adjusted average per capita cost (AAPCC). Financing will be on a risk basis. As broker, it markets to beneficiaries and counsels them as to which alternative health plans (AHP's) are available and what benefits each offers. Health Choice is also testing the impact of a voucher on beneficiaries. Half of the people in the Health Choice market area will receive a "nonnegotiable" voucher redeemable only at Health Choice. Health Choice has also provided assistance to organizations who wished to establish themselves as AHP's.

Status: This project began marketing in February 1985 with two health plans. A third plan will participate in July. Others may participate in the future.

Medicare Competition Demonstration

Project No.: 500-82-0042
Period: September 1982 - July 1984
Contractor: Maricopa County Department of Health Services
2601 East Roosevelt
Phoenix, Ariz. 85008
Project Officer: Sidney Trieger
Division of Health Systems and Special Studies

Description: The Maricopa County Department of Health Services (MCDHS) has established an alternative health plan, which is enrolling Medicaid eligibles under the Arizona Health Care Cost-Containment System. MCDHS plans to offer enrollment also to Medicare beneficiaries. They will receive payment from Medicare at 95 percent of the adjusted average per capita cost.

Status: MCDHS intended to provide a comprehensive range of benefits, including nursing services, typically associated with long-term care and not covered by Medicare. Implementation will depend on compliance with the Tax Equity and Fiscal Responsibility Act of 1982.

Medicare Competition Demonstration

Project No.: 500-82-0045
Period: September 1982 - March 1985
Funding: $ 531,360
Award: Contract
Contractor: Blue Cross of Massachusetts
100 Summer Street
Boston, Mass. 02106
Project Officer: Nancy Row
Division of Health Systems and Special Studies

Description: This project is testing alternatives to traditional Medicare financing and delivery of health services in Massachusetts. Reimbursement will be on a prepaid per capita basis, capitated at 95 percent of the adjusted average per capita cost. Financing is on a risk basis. Under this demonstration, Blue Cross of Massachusetts established a Senior Plan Network of four health maintenance organizations (HMO's) in the State. Each HMO competes with at least one other in its area.

Status: Blue Cross of Massachusetts began enrolling beneficiaries in October 1983. Initial enrollment (6,000 beneficiaries) for two of the plans was double the plans' projections. Combined enrollment for the four plans is 17,500. The demonstration ended on March 31, 1985, and the plans will continue serving Medicare beneficiaries under the Tax Equity and Fiscal Responsibility Act of 1982.

Medicare Competition Demonstration

Project No.: 500-82-0034
Period: September 1982 - March 1985
Award: Contract
Contractor: Metro Health, Inc.
931 East 86th Street
Suite 200
Indianapolis, Ind. 46240
Project Officer: Shelagh Smith
Division of Health Systems and Special Studies

Description: This project will test alternatives to traditional Medicare financing and delivery of health services in Indianapolis. The demonstration is being conducted by a federally qualified, staff model, health maintenance organization (HMO) with an enrollment of 68,000 members. The HMO is using one large teaching hospital exclusively for its Medicare enrollees and is implementing a risk-sharing arrangement with the hospital under which the hospital will receive a flat percentage of the adjusted average per capita cost. The Metro Health Plan (MHP) wants to test the cost effectiveness of competing for Medicare beneficiaries' enrollment in their plan based on offering an expanded package of benefits, including preventive and dental on a prospective capitation reimbursement system.

Status: MHP started enrolling Medicare beneficiaries under this prospective capitation arrangement in January 1984. Current enrollment in the demonstration is 4,200, with all 1,200 cost-contract beneficiaries converting and 3,000 new members joining. They operate from five facilities and plan to open another new facility in the coming year. The demonstration ended on March 31, 1985, and the plan will continue serving Medicare beneficiaries under the Tax Equity and Fiscal Responsibility Act of 1982.

Medicare Competition Demonstration

Project No.: 500-82-0047
Period: September 1982 - March 1985
Funding: $ 730,959
Award: Contract
Contractor: Health Care Network, Inc.
20800 Greenfield
Oak Park, Mich. 48237
Project Officer: Ronald Deacon
Division of Health Systems and Special Studies

Description: This project will test alternatives to traditional Medicare financing and delivery of health services in Detroit. Health Care Network (HCN), owned by Blue Cross of Michigan, is a group model operating in Detroit, a competitive community. HCN is offering a "Medinet" program for Medicare beneficiaries through a network of 25 primary care physician groups (PPG) composed of 8 to 25 physicians in each PPG. HCN will include measures for sharing risk for the network for referral services and hospital costs. Enrollees are required to use HCN-approved hospitals.

Status: The protocol was approved in December 1983 and the demonstration became operational in January 1984. HCN is being reimbursed 95 percent of the adjusted average per capita cost. Current enrollment is 2,000. The demonstration ended on March 31, 1985, and the plan will continue serving Medicare beneficiaries under the Tax Equity and Fiscal Responsibility Act of 1982.

Medicare Competition Demonstration

Project No.: 500-82-0038
Period: September 1982 - December 1985
Award: Contract
Contractor: Blue Cross and Blue Shield of Michigan (Blue Care)
600 Lafayette East
Detroit, Mich. 48226
Project Officer: Kathleen Farrell
Division of Health Systems and Special Studies

Description: This project will test alternatives to traditional Medicare financing and delivery of health services in Detroit. The project will accept 95 percent of the adjusted average per capita cost from the Health Care Financing Administration for Medicare beneficiaries enrolled in the Detroit area. It will then contract with preferred provider organizations, starting with Detroit Medical Center, to serve beneficiaries at favorable rates. Beneficiaries will not be locked into obtaining services through the plan; they will be allowed to seek services outside the plan provided they are willing to pay the traditional Medicare deductibles and coinsurance. This project will experiment with the concept that the financial incentives of no coinsurance or deductibles when services are received through plan providers will be sufficient to keep beneficiaries within the plan.

Status: The scheduled implementation date is June 1985. Blue Care anticipates enrolling approximately 5,000 Medicare beneficiaries by December 1985. When the demonstration period ends, continuation will depend on compliance with the Tax Equity and Fiscal Responsibility Act of 1982 requirements.

Medicare Competition Demonstration

Project No.: 500-82-0039
Period: September 1982 - March 1985
Award: Contract
Contractor: Group Health Plan of Southeast Michigan
5700 Crook Road
Troy, Mich. 48099
Project Officer: Ronald Deacon
Division of Health Systems and Special Studies

Description: This project will test alternatives to traditional Medicare financing and delivery of health services in Detroit. The demonstration will involve a federally qualified, staff model, health maintenance organization (HMO) that has been in operation since 1977. It serves 24,000 enrollees in the Detroit area, of which 2,000 are enrolled under a Medicaid risk contract. The HMO plans to enroll 1,000 Medicare beneficiaries.

Status: The protocol for this demonstration was approved in December 1983. The demonstration became operational in February 1984. Currently, there are 300 Medicare enrollees. The demonstration ended on March 31, 1985, and the plan will continue serving Medicare beneficiaries under the Tax Equity and Fiscal Responsibility Act of 1982.

Medicare Competition Demonstration

Project No.: 500-82-0040
Period: September 1982 - June 1987
Award: Contract
Contractor: Senior Health Plan
315 Iris Park Place
1885 University Avenue
Minneapolis, Minn. 55104
Project Officer: John Sirmon
Division of Health Systems and Special Studies

Description: This project involves the formation and testing of a new entity, a joint venture between St. Paul-Ramsey Medical Center, Amherst H. Wilder Foundation, and Health Central, Inc. This consortium will provide comprehensive medical and institutional services to an enrolled population, and will provide benefits additional to the standard Medicare package, particularly in long-term care. Extensive use of cost sharing is proposed to control utilization. The Health Care Financing Administration (HCFA) incorporated a modification to the standard adjusted average per capita cost (AAPCC) reimbursement method. Prior hospital utilization and Medicare Part B utilization are used in conjunction with current AAPCC factors to derive prospective rates for each plan member.

Status: Senior Health Plan (SHP) has completed and met all developmental requirements regarding participation as a Medicare HMO demonstration (e.g., protocol and marketing materials). SHP has received waiver and service agreement approval from HCFA and is operational. SHP will operate under a Medicare/Private Sector Membership Ratio System that will assure the plans compliance with the membership mix (50/50) requirements of the Tax Equity and Fiscal Responsibility Act of 1982. Current Medicare enrollment is 4,045.

Medicare Competition Demonstration

Project No.: 500-82-0041
Period: September 1982 - June 1985
Award: Contract
Contractor: Affiliated Professionals, Inc.
One Parkland Boulevard
Suite 1002 West
Dearborne, Mich. 48126
Project Officer: John Sirmon
Division of Health Systems and Special Studies

Description: This project will test alternatives to traditional Medicare financing and delivery of health services in Detroit, Michigan, and three surrounding metropolitan counties. Affiliated Professionals (APRO) is a health maintenance organization (HMO) management firm. APRO proposes to create a new HMO based on joint Medicare/private sector membership as required by the Tax Equity and Fiscal Responsibility Act of 1982. The plan will provide for participation by a large teaching hospital (Henry Ford Hospital), including the hospital's outreach clinic system. APRO will receive payments from the Health Care Financing Administration and disburse funds to the sites.

Status: APRO has completed and met all developmental requirements regarding participation as a Medicare HMO demonstration (e.g., protocol and marketing materials). APRO has received waiver and service agreement approval from the Health Care Financing Administration and is operational. Currently, APRO enrollment is 1,792 Medicare members and 3,500 private sector members. When the demonstration period ends, continuation will depend on compliance with the Tax Equity and Fiscal Responsibility Act of 1982.

Medicare Competition Demonstration

Project No.: 500-82-0030
Period: September 1982 - March 1985
Award: Contract
Contractor: American Medical Care and Review Association
5410 Grovesnor Lane
Bethesda, Md. 20814
Project Officer: Kathleen Farrell
Division of Health Systems and Special Studies

Description: The purpose of this Medicare competition demonstration is to develop and test alternative models of financing and/or delivering health care for Medicare beneficiaries that enhance competition. The American Medical Care and Review Association, a trade association of individual practice association model, health maintenance organizations (HMO's), is conducting a capitation demonstration to test a unique component that involves the establishment of a pooled-risk reserve to cover any losses of the HMO's. There are seven member plans. Each plan is reimbursed at 95 percent of the adjusted average per capita cost.

Status: The seven original member plans are operational: Health Plus (formerly Genesee Health Care) of Flint, Mich.; Central Massachusetts Health Care of Worcester, Mass.; South Florida Group Health of Miami, Fla.; Delmarva Health Care of Easton, Md.; Choicecare of Cincinnati, Ohio; Crossroads Health Plan of East Orange, N.J., and HealthOhio (formerly Marion HMO) of Marion, Ohio. As of November 1, 1984, the combined enrollment for the seven plans was 18,532 Medicare beneficiaries. The demonstration ended on March 31, 1985, and the plans will continue serving Medicare beneficiaries under the Tax Equity and Fiscal Responsibility Act of 1982.

Medicare Competition Demonstration

Project No.: 500-82-0035
Period: September 1982 - March 1985
Award: Contract
Contractor: Health America Corporation
3310 West End Avenue
Nashville, Tenn. 37203
Project Officer: Ronald Deacon
Division of Health Systems and Special Studies

Description: This project will demonstrate and test an alternative health plan. Health America Corporation is a national health maintenance organization (HMO) management firm that owns or manages 15 HMO's. The demonstration was to be conducted at eight sites. However, because of the promulgation of the regulations implementing the Tax Equity and Fiscal Responsibility Act of 1982, only one plan became operational under the demonstration (HealthAmerica of Broward in Ft. Lauderdale, Florida). The reimbursement is 95 percent of the adjusted average per capita cost.

Status: Health America of Broward became operational on February 1, 1983. The design phase, including protocol, waiver approval, service agreement signature, marketing, and systems changes, was completed for an effective date of February 1, 1983. More than 1,000 Medicare beneficiaries were enrolled as a result of their transfer from a HealthAmerica of Broward cost contract. As of October 1984, there were approximately 2,700 Medicare enrollees. The demonstration ended on March 31, 1985, and the plan will continue serving Medicare beneficiaries under the Tax Equity and Fiscal Responsibility Act of 1982.

Medicare Competition Demonstration

Project No.: 95-P-98256/2-02
Period: February 1983 - March 1985
Award: Grant
Grantee: Genesee Valley Group Health Association
Gateway Centre
150 East Main Street
Rochester, N.Y. 14647
Project Officer: Shelagh Smith
Division of Health Systems and Special Studies

Description: Genesee Valley Group Health Association (GVGHA) is a 10-year-old federally qualified, health maintenance organization (HMO) located in Rochester, N.Y. Group Health is competing for area beneficiaries by offering an expanded benefit package at a low premium with a lock-in provision. The HMO will accept 95 percent of the adjusted average per capita cost. Group Health had a cost contract and converted 1,240 of these beneficiaries into the demonstration.

Status: GVGHA's operational protocol and marketing materials were approved in September 1983. GVGHA started marketing activities in September and began offering services in December 1983. Currently, Medicare enrollees in the risk demonstration total 4,110, including a cost conversion group of 1,240. Overall enrollment in the HMO totals 38,000. They offer three separate options with premiums ranging from $15.00 to $30.00 per month. The demonstration ended on March 31, 1985, and the plan will continue serving Medicare beneficiaries under the Tax Equity and Fiscal Responsibility Act of 1982.

Medicare Competition Demonstration

Project No.: 95-P-98340/9-02
Period: June 1983 - June 1985
Award: Grant
Grantee: French Hospital Medical Center
4131 Geary Boulevard
San Francisco, Calif. 94118
Project Officer: Ronald Deacon
Division of Health Systems and Special Studies

Description: The purpose of the project is to test a hospital-based, health maintenance organization (HMO) model designed to enhance competition in the San Francisco area and provide increased choice for Medicare beneficiaries. French will accept reimbursement at 95 percent of the adjusted average per capita cost and will offer an enriched benefit package. Projected enrollment is 6,000.

Status: The project's operational protocol was approved in July 1984. An open enrollment period began in September 1984, with an October 1984 effective date. Current Medicare enrollment is 2,300. When the demonstration period ends, continuation will depend on compliance with the Tax Equity and Fiscal Responsibility Act of 1982 requirements.

Medicare Competition Demonstration

Project No.: 95-P-98338/0-01
Period: June 1983 - June 1985
Award: Grant
Grantee: Group Health Service Plan d.b.a. Healthcare
1800 I Street
Sacramento, Calif. 95814
Project Officer: Eric R. Nevins
Division of Health Systems and Special Studies

Description: The Group Health Service Plan is a federally qualified, group practice model, health maintenance organization (HMO) serving 15,000 enrollees in Sacramento. The Plan has been State-certified since 1978 and currently holds a Medi-Cal contract with 5,000 enrollees. This demonstration is similar in most respects to other Medicare competition demonstrations. Healthcare has enrolled beneficiaries on a voluntary basis and is being reimbursed at 95 percent of the adjusted average per capita cost. Among its goals, Healthcare plans to demonstrate that preventive health care, health promotion programs, and the delivery of health services by health care professionals other than physicians, such as physician assistants, are effective and well received by Medicare beneficiaries.

Status: Healthcare has enrolled approximately 700 Medicare beneficiaries in the Sacramento area and projects enrollment of 1,800 beneficiaries by the end of its first operational year. When the demonstration period ends, continuation will depend on compliance with the Tax Equity and Fiscal Responsibility Act of 1982 requirements.

Medicare Competition Demonstration

Project No.: 500-84-0049
Period: August 1984 - August 1989
Award: Contract
Contractor: Arizona Physicians Independent Practice Association
4041 North Central Avenue
Phoenix, Ariz. 85012
Project Officer: Ronald Deacon
Health Systems and Special Studies

Description: The purpose of this project is to test innovative alternatives to existing practices of financing and delivering health care to Medicare beneficiaries under competitive market conditions. As an independent practice association model, health maintenance organization, the demonstration will test how quality care can be provided to Medicare beneficiaries under a competitive delivery system at a reduced cost to the government (85 percent of the adjusted average per capita cost) and to the Medicare beneficiary.

Status: Arizona physicians independent practice association intends to submit an operational protocol in mid-1985.

Medicare Competition Demonstration

Project No.: 500-84-0050
Period: August 1984 - August 1989
Award: Contract
Contractor: Serra Medical Foundation
9375 San Fernando Road
Sun Valley, Calif. 91352
Project Officer: Eric Nevins
Health Systems and Special Studies

Description: The purpose of this project is to test innovative alternatives to existing practices of financing and delivering health care to Medicare beneficiaries under competitive market conditions. As a group model health maintenance organization, the demonstration will test how quality care can be provided to Medicare beneficiaries under a competitive delivery system at a reduced cost to the government (85 percent of the adjusted average per capita cost) and to the Medicare beneficiary.

Status: In late November 1984, Serra submitted a draft protocol of operations. It is anticipated that the design and development stage will be completed for operations to commence in Summer 1985.

Alternate Models for Prepaid Capitation of Health Care Services for Medicare Recipients--Oregon

Project No.: 500-78-0078
Period: September 1978 - March 1985
Funding: $ 1,044,160
Award: Contract
Contractor: Kaiser Foundation
Health Services Research Center
4610 Southeast Belmont Street
Portland, Oreg. 97215
Project Officer: Nancy Row
Division of Health Systems and Special Studies

Description: This prospective risk capitation, Medicare health maintenance organization demonstration is testing a reimbursement methodology based on 95 percent of the adjusted average per capita cost in the Kaiser Portland/Oregon region. The savings between the capitation rate and the adjusted community rate is returned to the beneficiaries in the form of increased benefits, reduced cost sharing, or both. A variety of marketing approaches were tested.

Status: This project has had 4 years of operational experience. Enrollment currently stands at approximately 8,000. The demonstration ended on March 31, 1985, and the plan will continue to serve Medicare beneficiaries under the Tax Equity and Fiscal Responsibility Act of 1982. The completed evaluation of the project is expected in late 1985.

Senior Group Health Plan Waiver-Only Medicare Competition Demonstration Program

Project No.: 95-C-98625/4-01
Period: October 1984 - September 1988
Award: Cooperative Agreement
Awardee: Finlay Medical Centers HMO Corporation
1401 Brickell Avenue, Suite 603
Miami, Florida 33131
Project Officer: Shelagh A. Smith
Health Systems and Special Studies

Description: Finlay Medical Centers HMO Corporation received a waiver-only cooperative agreement award on October 1, 1984, renewable on an annual basis for 4 years. Finlay is a staff-model, health maintenance organization (HMO) that is State-qualified and plans to implement a risk capitation at 85 percent of the adjusted average per capita cost in Dade and Broward Counties in Florida. They serve approximately 10,000 fee-for-service Medicare beneficiaries and 17,000 private enrollees. Finlay proposes to offer prescription drugs, eye examinations and glasses, hearing examinations and aids, and a dental plan at no premium to the Medicare enrollees. Projected Medicare enrollment for the first year is 17,000.

Status: Finlay submitted its draft protocol with marketing materials in November 1984. They began marketing February 1, 1985, and began enrolling March 1, 1985, with 345 members joining.

Development, Implementation, and Management of Medicare Competition Demonstrations

Project No.: 500-83-0005
Period: November 1982 - December 1984
Funding: $ 275,000
Award: Contract
Contractor: Birch and Davis Associates, Inc.
8905 Fairview Road
Silver Spring, Md. 20910
Project Officer: Ronald Deacon
Division of Health Systems and Special Studies

Description: This contractor provides technical support for the Medicare competition demonstrations. Institutional surveys are conducted to establish the adjusted average per capita costs (AAPCC) for the alternative health plans located in States where the Medicaid agencies are unable to furnish the required information on institutionalized Medicare beneficiaries. AAPCC's are computed using a methodology approved by the Office of the Actuary, Health Care Financing Administration, and an actuarial consultant.

Status: The contract ended in December 1984. Institutional surveys have been conducted in 10 States. Birch and Davis completed 118 AAPCC calculations for demonstrations in 18 States.

Evaluation of Health Maintenance Organization (HMO) Capitation Demonstrations

Project No.: 500-81-0017
Period: February 1981 - June 1985
Funding: $ 2,272,672
Award: Contract
Contractor: Jurgovan and Blair, Inc.
51 Monroe Street
Rockville, Md. 20850
Project Officer: Alan Friedlob
Division of Long-Term Care Experimentation

Description: This evaluation examines the experience of eight health maintenance organizations (HMO's) who have contracted with the Health Care Financing Administration (HCFA) under a prepaid, at-risk basis to provide services to Medicare beneficiaries. These demonstrations are the precursors of current legislation contained in the Tax Equity and Fiscal Responsibility Act of 1982, Section 114. The evaluation's objectives are:

- To measure HMO versus fee-for-service differences in utilization patterns for Medicare beneficiaries, standardizing for population differences.
- To assess the accuracy of HCFA's method of estimating what HMO enrollees would have cost under fee-for-service (that is, for the adjusted average per capita cost or AAPCC).
- To measure the extent to which either favorable or adverse selection has occurred, and the cost impact of selection bias in enrollment.
- To assess the cost effectiveness of different marketing methods to the Medicare beneficiary population.
- To assess the fiscal impact of the demonstrations for HCFA, for the HMO, and for beneficiaries.
- To examine the organizational changes in both the administrative and delivery systems conditioned by the addition of seniors to HMO membership.
- To analyze the implications of the demonstrations for national policy.

Status: An actuarial critique of the AAPCC was completed in April 1982. A survey of Medicare beneficiaries who joined the plans and those who chose not to enroll has been completed in Marshfield, Wis., Worcester, Mass., and Minneapolis-St. Paul, Minn. Survey findings are available. Reports examining rate-setting issues, the operational issues facing HMO's and competitive medical plans contemplating risk-based Medicare contracting, and marketing Medicare in a competitive environment have been completed. The report entitled, Health Maintenance Organization Risk Contracting Under Medicare has been published in the Grants and Contract Series and is available only from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402, Stock No. 017-060-00163-1, price $5.50.

Evaluation of the Medicare Competition Demonstrations

Project No.: 500-83-0047
Period: October 1983 - December 1987
Funding: $ 3,160,190
Award: Contract
Contractor: Mathematica Policy Research, Inc.
P.O. Box 2393
Princeton, N.J. 08540
Project Officer: James Hadley
Division of Health Systems and Special Studies

Description: The Health Care Financing Administration is sponsoring an evaluation of a major series of demonstrations, designed to introduce significant competition into the market for providing health services to Medicare beneficiaries. The demonstrations involved more than 50 health maintenance organizations and other competitive medical plans (CMP's) throughout the United States that provide health services to Medicare beneficiaries for a prospectively determined payment. This evaluation focuses on the following major policy issues:

- What are the impacts of enrollment of Medicare beneficiaries by CMP's under risk-based capitation on the use, quality, and cost of care?
- What are the determinants of consumer choice of CMP's? What marketing strategies are pursued by CMP's?
- What are the impacts on the fee-for-service sector of risk-based capitation payments to CMP's under Medicare?
- How do CMP's compete with one another and with the fee-for-service sector within the same market area?

Status: The evaluation began in October 1983. Preliminary findings will be available in the project's first annual report in March 1985.

Evaluation of Medicare Health Maintenance Organization Demonstration Projects

Funding: Intramural
Project Officers: Judith Kasper and Alan Friedlob
Division of Beneficiary Studies and Division of Long-Term Care Experimentation

Description: This study evaluates demonstration projects undertaken to encourage health maintenance organizations (HMO's) to participate in the Medicare program under a risk mechanism. Three demonstration HMO's are included in the study: the Fallon Community Health Plan, the Greater Marshfield Community Health Plan, and the Kaiser-Permanente Medical Program of Portland, Oreg. The study includes 18,085 aged Medicare beneficiaries who had enrolled in the plans as of April 1981. Also included are comparison groups from a 5-percent random sample of aged Medicare beneficiaries living in the same geographic areas as the control groups. The evaluation examines issues such as biased selection, patterns of prior and post-enrollment use by HMO enrollees, and comparisons of use and expenditure patterns by HMO and non-HMO beneficiaries.

Status: The evaluation is in the planning stages. Final data acquisition from the three sites and creation of data files are nearly complete.

Santa Barbara Health Initiative

Project No.: 11-P-98036/9-03
Period: September 1981 - December 1984
Funding: $ 424,364
Award: Grant
Grantee: California Department of Health Services
714/744 P Street
Sacramento, Calif. 95814
Project Officer: Eric R. Nevins
Division of Health Systems and Special Studies

Description: This demonstration is supporting the Santa Barbara Health Initiative (SBHI) in the development and testing of a primary care network to serve all categories of the Medicaid population. The SBHI is reimbursed at 95 percent of projected fee-for-service expenditures and assumes risk for Medicaid services. The primary care physicians act as case managers, providing primary care and authorizing referrals when necessary. The SBHI advances block payments to hospitals as an incentive to participate and is responsible for proper utilization as controlled by the primary care physician. SBHI plans to demonstrate that the Medi-Cal program can be operated more efficiently on a county level, with greater participation of private and public physicians and other providers.

Status: The health care of the entire Medi-Cal population in Santa Barbara County (approximately 25,000 beneficiaries) is the responsibility of this demonstration project. One of the major tasks completed involved the development of an acceptable operational protocol as required by the Health Care Financing Administration. Other tasks include:

- Negotiating contracts with providers throughout the county, including 8 hospitals and 432 physicians.
- Securing an exemption from Knox-Keene legislation, a State law covering financial requirements for health maintenance organizations.
- Selecting Jurgovan and Blair, Inc., to develop and implement the claims processing and management information system.

The first year financial experience for SBHI has been good with SBHI operating in a surplus position. SBHI is obligated to share a certain percentage of the balance with providers after the year's end.

Monterey County Health Initiative

Project No.:	11-P-98035/9-03
Period:	September 1981 - April 1986
Funding:	$ 369,490
Award:	Grant
Grantee:	California Department of Health Services 714/744 P Street Sacramento, Calif. 95814
Project Officer:	Eric R. Nevins Division of Health Systems and Special Studies

Description: This project was designed to develop and test a capitated primary care network to serve all categories of the Medicaid population in Monterey County. The Monterey Health Initiative (MHI) was organized as a case-management network focusing on the primary physician. The MHI was reimbursed at 95 percent of the projected expenditures and had assumed risk for Medicaid services. Primary physician accounts were set up to monitor incoming funds and outgoing expenses. Physicians will be at risk for losses or savings that accumulate in the accounts.

Status: MHI will be terminating early due to financial difficulties of the program. MHI was set up to test whether a case management/primary care network model could control health care costs without impairing the quality of care provided, while maintaining fee-for-service payments to physicians and hospitals. MHI was capitated at the rate of 95 percent projected fee-for-service costs. MHI has experienced a deficit of approximately $4 million since it became operational in June of 1983. Medicaid recipients will revert back to the fee-for-service system as of March 1, 1985. To assure continuity of care for recipients, MHI will reimburse providers for care delivered during February 1985, before distributing on a pro-rata basis available funds to meet existing liabilities for past care. The external evaluation of the Monterey demonstration will be continued to determine the reasons for its difficulties and to compare the model with the relative success of the Santa Barbara Health Initiative.

Florida Alternative Health Plan Project

Project No.: 11-P-98231/4-02
Period: June 1982 - June 1986
Funding: $ 729,114
Award: Grant
Grantee: State of Florida
1317 Winewood Boulevard
Tallahassee, Fla. 32301
Project Officer: Ronald Deacon
Division of Health Systems and Special Studies

Description: This project is designed to demonstrate and test a number of methods for promoting competition among health care providers and insurers. The competitive models include:

- Competitive alternative health plans (competitive procurement process).
- Recipient case management (case management focused on overutilizers).
- Alternative health plan for the frail elderly (risk contracts with organizations to provide health, home, and community-based services on a prepaid basis).
- Medical care vouchers (consumer choice model utilizing nonnegotiable vouchers).

Status: Two health maintenance organizations in Dade County responded to the competitive bid model, but the State did not proceed through the procurement process because of a protest filed by one bidder. The State has decided to contract with health maintenance organizations through individual negotiation rather than competitive bidding. Three different organizational models for recipient case management are to be tested in Jacksonville, Tampa, and Orlando. One model in Tampa is operational; the others will become operational in 1985. A final protocol for the frail-elderly module is to be submitted by June 1985. The State is not planning to submit a protocol for the voucher model.

Medicaid Voucher Demonstration

Project No.: 11-P-98223/5-02
Period: June 1982 - June 1986
Funding: $ 556,160
Award: Grant
Grantee: Minnesota Department of Public Welfare
2nd Floor-Space Center
444 Lafayette Road
St. Paul, Minn. 55101
Project Officer: Eric Nevins
Division of Health Systems and Special Studies

Description: This project is designed to test a Medicaid capitation demonstration with the following major objectives:

- To further the evolution of a competitive health care system by shifting a publicly supported program (Medicaid) to a prepaid basis.
- To control public expenditures for health care by switching from an open-ended provider/consumer-induced demand system to a budgeted, prepaid reimbursement system.
- To create and test various policies and systems for prepaid Medicaid programs.

Status: The project is expected to incorporate a means to convert a substantial portion of the Medicaid population in three counties (an urban, suburban, and rural county) to a prepaid, prospective risk, capitation reimbursement system. If successful, this demonstration should further intensify provider competition in the chosen counties while arresting the cost spiral in the State program. A draft protocol was submitted providing only for the participation of a rural county. The Health Care Financing Administration is extending the design phase so that an urban and suburban county may be included. Operations are expected to commence during Summer 1985.

Arizona Health Care Cost-Containment System

Project No.: 11-P-98239/9-03
Period: June 1982 - June 1985
Award: Grant
Grantee: AHCCCS Administration
124 West Thomas
Phoenix, Ariz. 85013
Project Officer: Sidney Trieger
Division of Health Systems and Special Studies

Description: This project is designed to test the effectiveness of establishing under the Social Security Act, Title XIX, a Medicaid program based on competitive principles, including primary care physicians acting as gatekeepers, prepaid capitated contracts, competitive bidding, the use of nominal copayments, limited restrictions on freedom of choice, and capitated payment by the Health Care Financing Administration.

Status: Arizona Health Care Cost-Containment System (AHCCCS) was implemented October 1, 1982. Completed milestones include: approval of a Section 1115 waiver application and a State plan; development and approval of a capitation rate; and approval of a second- and third-year continuation application. The State awarded contracts to 19 prepaid health plans for the second year and 18 for the third year of the AHCCCS demonstration. The second open enrollment period was held, and the program is now in its third year of operation. The contract by the State with MCAUTO Systems, the contractor originally responsible for the administration of AHCCCS, had experienced significant cost overruns. Effective March 15, 1984, the State terminated their contract with MCAUTO and assumed full responsibility for administering the program. The State plans to request a 2-year extension of the AHCCCS program and will submit a continuation proposal.

Evaluation of the Arizona Health Care Cost-Containment System

Project No.: 500-83-0027
Period: June 1983 - September 1986
Funding: $ 2,489,488
Award: Contract
Contractor: SRI International, Inc.
333 Ravenswood Avenue
Menlo Park, Calif. 94025
Project Officer: Paul Lichtenstein
Division of Health Systems and Special Studies

Description: This project will evaluate the implementation, operation, and impact of the Arizona Health Care Cost-Containment System (AHCCCS), which is a unique and innovative State-sponsored demonstration that provides public assistance medical care (medical assistance) to residents of Arizona who are eligible for Aid to Families with Dependent Children and Supplemental Security Income cash payments. The study will focus on measuring the effects of AHCCCS on cost, quality, and utilization of health care as well as issues related to patient access and satisfaction. The following major innovative cost-containment methods, which are unique to Arizona among all State Medicaid Programs, will be evaluated:

- Capitation prepayment contracts, awarded as a result of competitive bidding, to health care plans that provide or arrange for the provision of covered services.
- "Gatekeeping" by a primary care physician who will be responsible for either providing or authorizing the services to be reimbursed for the enrollees, including any services provided by specialists.
- Use of nominal copayments as a means of inhibiting unnecessary utilization.
- Restriction on freedom-of-choice of plans and providers.
- Capitated payment of Federal financial participation by the Health Care Financing Administration to the State of Arizona based on the number of enrollees.

Status: To date, SRI has produced the following documents:

- A literature review on the major study topics and the methodologies for their evaluation.
- An evaluation plan that details the issues to be addressed by the study and the methodological approaches to be utilized.
- A preliminary case study which describes the events that occurred during the first 18 months of the AHCCCS program operation.

Missouri Medicaid Prepaid Health Demonstration Project

Project No.: 11-P-98225/7-03
Period: June 1982 - June 1986
Funding: $ 393,917
Award: Grant
Grantee: Missouri Department of Social Services
P.O. Box 88
Jefferson City, Mo. 65103
Project Officer: Eric R. Nevins
Division of Health Systems and Special Studies

Description: This project will demonstrate and test a citywide consumer choice model for Medicaid in Kansas City, Mo. The project incorporates components of competitive systems including:

- Consumer choice among alternative health plans.
- Risk sharing based on capitated reimbursements.
- A variety of marketing incentives.
- Participation of a range of organizational types.

All participating plans will offer the mandatory minimum benefit package for the categorically needy under the prepaid arrangement.

Status: The project became operational in January 1984. Missouri has contracted with five prepaid health plans and 50 physician sponsors to participate in the program. The health plans include Swope Parkway, Total Health Care/Prevention Plus, Truman Medical Center, University of Health Sciences, and Wayne Miner Neighborhood Health Center. The providers started delivering services on January 5, 1984. There are currently about 25,000 enrollees in the Managed Health Care Program. All 30,000 current Aid to Families with Dependent Children eligibles in Jackson County will be enrolled in the Managed Health Care Program by December 1984. The physician sponsors are reimbursed on a fee-for-service basis for medical services provided to enrollees and receive a case management fee of $1.50 per recipient per month. Prepaid health plans receive a set payment per member per month and must provide all covered services to clients within the total amount of the capitation payment.

Statewide Medicaid Competition Demonstration

Project No.: 11-P-98222/2-03
Period: June 1982 - June 1986
Funding: $ 792,552
Award: Grant
Grantee: New Jersey Department of Human Services
324 East State Street
Trenton, N.J. 08625
Project Officer: Eric R. Nevins
Division of Health Systems and Special Studies

Description: This project will demonstrate and test a competitive model in which Medicaid eligibles may select primary care providers as case managers for 6-month intervals that will be responsible for all direct primary care delivery and referrals for ancillary services for noninstitutional recipients. Case managers will be reimbursed on a capitation principle and will be at risk for selected services. The State will contract with broker organizations selected through a bidding process that will be responsible for:

- Marketing to case managers and eligibles.
- Enrolling case managers and eligibles.
- Quality control monitoring.
- Operation of a grievance procedure system for providers and eligibles.

The Professional Standards Review Organization has been selected as the broker for the first phase.

Status: Phase I of the Medicaid personal physician plan (MPPP) implementation began in July 1983, and continued through December 1983. During this period, State officials, assisted by La Jolla consultants, established the administrative, marketing, and enrollment processes for the Plan. Phase I of the project was implemented in Morris, Sussex, and Warren Counties. Although Phase I has ended, physician and patient enrollment continues through the efforts of the broker and local social service agencies. Phase II of the plan has begun and it expands the project into Atlantic, Burlington, Camden, Mercer, and Middlesex Counties. These counties include cities with more concentrated Medicaid populations than Phase I. The State has signed up 187 physicians as case managers. To date, 4,000 beneficiaries have expressed an intention to enroll, 3,000 have selected case managers, and 2,000 are receiving services under the plan. The State has also begun to implement the project in selected sites in Newark, Paterson, and Plainfield.

Monroe County MediCap Plan

Project No.: 11-P-98230/2-03
Period: June 1982 - August 1986
Funding: $ 700,322
Award: Grant
Grantee: New York Department of Social Services
40 North Pearl Street
Albany, N.Y. 12243
Project Officer: Nancy Row
Division of Health Systems and Special Studies

Description: Monroe County and New York State will participate in a reimbursement demonstration involving a prepaid capitated rate for Medicaid clients involved in the MediCap plan. Participating clients will be required to select a provider from a large set of providers who have arranged to provide services through Rochester Health Network, an health maintenance organization (HMO). After 6 months of implementation, MediCap expects to involve other area HMO's. A capitated rate, equal to or less than 95 percent of fee-for-service, will be agreed on between the State and the county. The county will, in turn, develop rates for categories of eligibles with possible adjustments for types of delivery systems.

Status: This project is in its developmental phase. A final protocol was scheduled to be submitted by December 1984, with enrollment to begin May 1985. An extensive data base is being developed to construct the Medicaid capitated rate.

Competitive Managed Health Plans for AFDC Medicaid Recipients

Project No.: 11-P-98330/1-02
Period: March 1983 - March 1986
Award: Grant
Grantee: Massachusetts Department of Public Welfare
600 Washington Street
Boston, Mass. 02111
Project Officer: Marla Aron
Division of Health Systems and Special Studies

Description: This project is designed to demonstrate and evaluate five models of "managed health care," developed by the Massachusetts Medicaid program for recipients of Aid to Families with Dependent Children (AFDC), in terms of cost, utilization, consumer satisfaction, administration, and quality of care. The five models are: case management, health maintenance organizations (HMO), ambulatory capitation, capitated dental program, and fiscal intermediary.

Status: All five models, except the fiscal intermediary model, are operational. The case-management model serves more than 5,000 clients, the HMO's serve almost 4,000 clients, the ambulatory-capitation model serves about 1,000 clients, and the dental program serves more than 1,000 clients. In the case-management model, a case-management fee for providers has been implemented. A 6-month guaranteed eligibility and a cash incentive for recipient participation have not been tested this year. Different marketing strategies for increasing provider and recipient participation are being evaluated.

Evaluation of the Medicaid Competition Demonstrations

Project No.: 500-83-0050
Period: September 1983 - September 1987
Funding: $ 3,098,938
Award: Contract
Contractor: Research Triangle Institute
P.O. Box 12194
Research Triangle Park, N.C. 27709
Project Officer: Spike Duzor
Division of Health Systems and Special Studies

Description: The Medicaid demonstrations are being implemented in six States (California, Florida, Minnesota, Missouri, New Jersey, and New York) to enhance the role of competition in the delivery of publicly financed Medicaid services. The evaluation is designed to describe and analyze the separate demonstrations, as well as to conduct a comparative impact analysis across the projects. A series of case studies and analytical reports will be done, highlighting the impact of the demonstrations' cost-containment modalities and their subsequent effect on quality of care, patient utilization, and patient satisfaction.

Status: Detailed case studies highlighting the status of each demonstration are currently available. A finalized research design, a data collection plan, and primary data collection instruments are also available. Second-year case studies and a detailed description of the rate-setting process for the operational States will be completed by Summer 1985.

Health Status Measure for Adjusting Health Maintenance Organization Rates for Medicare Beneficiaries

Project No.: 18-P-98179/5
Period: March 1982 - September 1984
Funding: $ 213,219
Award: Grant
Grantee: University of Michigan
School of Public Health
109 Observatory Street
Ann Arbor, Mich. 48109
Project Officer: Penelope Pine
Division of Program Studies

Description: This study investigates the use of a health status measure to improve the current method for reimbursing health maintenance organizations for Medicare beneficiaries under the at-risk alternative in Section 1876 of the Social Security Act. The project also explores the ability of simple measures of perceived health status obtained through telephone and mail surveys to predict future utilization and costs for a Medicare population.

Status: Field work has been completed on the survey of 3,000 Medicare beneficiaries in Michigan. Data from Blue Cross/Blue Shield of Michigan, Michigan Medicaid, and the Medicare Statistical System (Health Care Financing Administration) have been obtained and compared with the survey data. Major analytic findings of the study are (1) indirect measures of health status, including utilization and prior-year payment variables, provide better predictions than do direct measures of health status and (2) of the direct measures of health status considered in this research, the best single measure for predicting future use and costs is the Instrumental Activities of Daily Living score derived from the Rosow-Breslau Functional Health Scale.

Adjusted Average Per Capita Cost

Funding: Brandeis University Health Policy Research Consortium
(See page 174)
Project Officer: James Lubitz
Division of Beneficiary Studies

Description: The Brandeis University Health Policy Research Consortium, as part of its grant, is studying ways to improve the current adjusted average per capita cost (AAPCC). The work has been focused on three areas:

- The use of prior utilization to predict future utilization.
- The use of indicators of disability in the AAPCC.
- Analysis of risk sharing and reinsurance for Medicare health maintenance organizations (HMO's).

Status: Prior utilization--Results indicate that prior utilization is a significant predictor of future utilization. The predictive power is improved when prior hospital stays are classified into those for self-limiting conditions and those for conditions, like cancer, indicative of chronic, recurring problems. Work is continuing to refine an AAPCC model incorporating diagnostic information on prior hospital stays. Preliminary results are contained in "Prediction of Subsequent Year Reimbursement Using the Medicare History File" by Jennifer Anderson and Abby Resnick, Brandeis University Health Policy Consortium, Discussion Paper, May 1982.

Disability level--Results indicate that disability level is a significant predictor of health care use. A disability level factor, therefore, would theoretically improve the current AAPCC. However, any improvement would have to be weighed against the cost and administrative burden of acquiring disability data on Medicare enrollees. A discussion of a possible disability adjustment is contained in two draft papers from the Consortium by Leonard Gruenberg and Neil Stuart, "A Health Status-Based AAPCC: The Disability Level Based Approach," and "The Use of Disability Status as a Health Status Measure for Updating a Prior Utilization Reimbursement Model."

Reinsurance--Preliminary work has been completed on a number of reinsurance models. Brandeis is now working on plans to test modifications to the AAPCC based on their research in a number of demonstration projects. Brandeis is also working with HCFA to develop a long-term research strategy to change the way Medicare pays HMO's to encourage increased HMO participation and cost effectiveness.

Research to Improve the Adjusted Average Per Capita Cost Formula to Pay Health Maintenance Organizations

Funding: Intramural
Project Director: James Lubitz
Division of Beneficiary Studies

Description: Medicare payment to at-risk health maintenance organizations (HMO's) is based on the adjusted average per capita cost (AAPCC) formula, which uses the enrollee's age, sex, welfare status, and institutional status as underwriting factors. Recent studies in the Office of Research and Demonstrations, Health Care Financing Administration, have shown that the AAPCC may not adequately adjust for biased selection of lower-than-average users of health services into HMO's. There has also been concern about a number of technical aspects of the AAPCC. The passage of the Tax Equity and Fiscal Responsibility Act in 1982 gave added importance to the AAPCC formula, because the new law is expected to greatly increase the number of at-risk HMO's in Medicare. The AAPCC studies examine both ways to improve the current AAPCC and the effect of adding additional underwriting factors to the formula.

Status: Current projects are investigating the use of underwriting factors based on prior use of health services, prior entitlement to Social Security disability benefits, prior entitlement to Supplemental Security Income benefits, and early retirement. The following working papers have been produced:

- "An Examination of the Geographic Factor Used in the AAPCC."
- "Two Studies in the Evaluation of the AAPCC: A Study of the Sensitivity of the AAPCC to the Institutional Underwriting Factors, and Predicting Reimbursement with the AAPCC Underwriting Factors."

Former Disability as an Adjustment Factor for the Adjusted Average Per Capita Cost

Funding: Intramural
Project Director: Jerry Riley
Division of Beneficiary Studies

Description: Medicare data show that approximately 8 percent of Medicare beneficiaries 65-69 years of age were formerly entitled to Medicare because of disability. These beneficiaries tend to incur nearly twice as much reimbursement as other beneficiaries their age. Consequently, the Office of Research will develop and test an additional factor for the adjusted average per capita cost (AAPCC) that will adjust for previous receipt of Social Security disability benefits among aged enrollees. Included in the study will be beneficiaries who were formerly entitled to disability benefits under Social Security, but were never Medicare entitled.

Status: The Social Security Administration will provide updated information on former receipt of disability benefits for a sample of Medicare beneficiaries. This information will be linked to data from the Medicare Continuous History File. It is anticipated that results of the study will be available in 1985.

Use of Prior Utilization for Prospective Payment of Health Maintenance Organizations

Funding: Intramural
Project Director: James Beebe
Division of Beneficiary Studies

Description: The Tax Equity and Fiscal Responsibility Act of 1982 permits health maintenance organizations (HMO's) to receive prospective payments for their enrollees. The amount of payment is to be determined by the characteristics of the HMO's enrollees. The current adjusted average per capita cost relies on demographic characteristics of the HMO enrollees. There is considerable evidence that, even when controlling for demographic variables, HMO enrollees tend to be healthier than the general Medicare population. This research investigates the feasibility of using prior utilization along with demographic characteristics to control for this bias and more accurately predict future medical costs. The utilization variables being investigated (prior hospital days and whether or not the Part B, Supplementary Medical Insurance deductible was met) were chosen because they are readily available from the Medicare administrative data system.

Status: The study found that for groups of persons with high or low levels of prior utilization, the models which include prior-use variables predict reimbursement better than models containing only demographic variables. However, there is still room for improvement. Future work will concentrate on models that incorporate diagnosis for prior hospital stays. A working paper entitled, "Using Prior Utilization Information to Determine Payments for Medicare Enrollees in HMO's" has been produced. An article based on the report is to be published in the Spring 1985 Health Care Financing Review.

Using a Prior-Use Adjusted Average Per Capita Cost to Set Capitation Rates for a Minnesota Health Maintenance Organization

Funding: Intramural
Project Director: James Beebe
Division of Beneficiary Studies

Description: The Office of Research has developed adjusted average per capita cost (AAPCC) models which use prior Medicare use and demographic variables to predict future reimbursement. These models will be used to set capitation rates for certain enrollees in Senior Health Plan, a demonstration health maintenance organization (HMO) in Minnesota. The HMO expects to attract persons of less than average health and feels that the current AAPCC method of payment would not cover their costs. This will be the first actual test of a prior-use model for payment.

Status: The HMO and the Office of Research and Demonstrations have agreed on the formulas that will be used to reimburse enrollees for the first 2 years of the demonstration. The third and last year of the demonstration may be paid under the current AAPCC methodology or by methods now being developed. Payment under the new system began in January 1985.

Medicare Reimbursement Regression to the Mean

Funding: Intramural
Project Director: James Beebe
Division of Beneficiary Studies

Description: Several recent studies have shown that persons who join health maintenance organizations (HMO's) tend to be lower users of health care services prior to joining than the general population. This suggests that they may be healthier. If so, the current payment method will overpay HMO's. Critics of the studies claim that the problem is overstated because any group of high or low users will become average users (regress to the mean) over a period of time. This study is intended to measure the extent to which high- and low-use Medicare beneficiaries regress to the mean and to explore whether these measures can be useful in setting capitation payments for HMO's.

Status: Data files have been formed and preliminary work completed. A draft paper is complete.

Medicare Health Maintenance Organization Additional Benefits

Funding: Intramural
Project Director: Judith Sangl
Division of Reimbursement and Economic Studies

Description: Section 114 of Public Law 97-248, the Tax Equity and Fiscal Responsibility Act of 1982, requires that, to the extent a health maintenance organization's (HMO) Medicare payment exceeds its adjusted community rate under a risk-sharing contract, the HMO must use the savings to provide its Medicare members additional benefits or reduced cost sharing. Section 114 also requires that the Secretary of the Department of Health and Human Services conduct a study of the additional benefits provided under this provision. This study will report on the number of HMO's subject to the additional benefits requirement, and the nature of the benefits that HMO's choose to provide.

Status: The study depends on data that will be collected in 1985. This information will be compiled in a report due to Congress in late 1986.

Social Health Maintenance Organizations

Social Health Maintenance Organization Project for Long-Term Care

Project No.:	18-C-97604/1-05
Period:	March 1980 - May 1986
Funding:	$ 1,553,478
Award:	Cooperative Agreement
Awardee:	Brandeis University Health Policy Center 415 South Street Waltham, Mass. 02254
Project Officers:	Tom Kickham and Sidney Trieger Divisions of Long-Term Care Experimentation and Health Systems and Special Studies

Description: In accordance with the Congressional mandate (Public Law 98-369, Section 2355), this project will develop and implement the concept of a social health maintenance organization (S/HMO) for long-term care. An S/HMO integrates health and social services under the direct financial management of the provider of services. All services would be provided by or through the S/HMO at a fixed annual prepaid capitation sum.

Status: Four S/HMO demonstration sites have been selected by the Health Policy Research Center. These sites include two HMO types that will be adding long-term care services to their service packages, and two long-term care providers that will be adding acute care services to their service packages. The Consortium has been successful in assisting the sites in obtaining private foundation funding to finance the development period. The center and the sites have developed a common service package, financing plans, and risk-sharing arrangements. The sites have received approval of their final protocols and applications for Medicare and Medicaid waivers.

The four sites will initiate service delivery by March 1985. The S/HMO sites are:

- Elderplan Inc.
  Sponsor: Metropolitan Jewish Geriatric Center
  Brooklyn, New York
  Project Officer: William Clark

- Seniors Plus
  Sponsors: Group Health Inc. and Ebenezer Society
  Minneapolis, Minnesota
  Project Officer: John Sirmon

- Medicare Plus II
  Sponsors: Kaiser-Permanente Medical Care Program
  Portland, Oregon
  Project Officer: Nancy Row

- Senior Care Action Network Health Plan
  Sponsor: Senior Care Action Network
  Long Beach, California
  Project Officer: William D. Clark

Other Alternative Payment Systems

California State Copayment Project

Project No.: 11-P-98206/9-03
Period: March 1982 - March 1985
Award: Grant
Grantee: California Department of Health Services
714/744 P Street
Sacramento, Calif. 95814
Project Officer: John F. Meitl
Division of Health Systems and Special Studies

Description: The purpose of this project is to determine if nominal copayments will reduce inappropriate use of health services without affecting needed services. Copayments are limited to ambulatory services and are collected by the provider. Early and Periodic Screening, Diagnosis, and Treatment eligibles and Medicare beneficiaries are exempt from all copayments. Copayments are, with some exceptions: $1 for each outpatient clinic or physician-type visit; $5 for each visit for nonemergency services received in an emergency room; and $1 for each drug prescription.

Status: The medical procedures used in evaluating the effect of copayment on Medi-Cal beneficiaries have been identified and categorized. Printouts of data on the utilization of these procedures have been completed by the California Center for Health Statistics and have been forwarded to the California Department of Health Services, Surveillance and Utilization Review Branch, for analysis.

National Medical Care Utilization and Expenditure Survey

Analysis of NMCUES Data

Project No.: 500-81-0047
Period: September 1981 - March 1985
Funding: $ 4,698,452
Award: Contract
Contractor: Research Triangle Park Institute
P.O. Box 12194
Research Triangle Park, N.C. 27709
Project Officer: Herbert Silverman
Division of Program Studies

Description: This project involves the analysis of data (tabulations, models, and data file production) and the publication of series reports on the National Medical Care Utilization and Expenditure Survey (NMCUES). This survey was cosponsored by the Office of Research and Demonstrations, Health Care Financing Administration, and the National Center for Health Statistics, Public Health Service. NMCUES was used to collect detailed sociodemographic, health status, health insurance, and health care payment data that were not available from either the Medicare or Medicaid administrative record systems. Data were obtained from three survey components:

- A randomly selected national household sample (HHS) of the civilian noninstitutionalized population.
- Randomly selected State Medicaid household samples (SMHS) of the civilian noninstitutionalized Medicaid population in four States: California, Michigan, Texas, and New York.
- A Medicare and Medicaid administrative records survey (ARS) linked to HHS and SMHS Medicare and Medicaid respondents.

The data collected will allow for analysis of policy issues that include the New Federalism, Medigap, out-of-pocket costs, and benefit package changes.

Status: The contract is now in its report production phase. The reports will emphasize the relationship of utilization to health insurance coverage, out-of-pocket expenditures, access to health care, and Medicaid use by social and ethnic groups. The following NMCUES reports are currently available:

- "Health Status of Aged Medicare Beneficiaries," DHHS Pub. No. 83-20202, September 1983.
- "Access to Health Care Among Aged Medicare Beneficiaries," DHHS Pub. No. 84-20203, April 1984.

Perspectives on Health Care from National Medical Care Utilization and Expenditure Survey: United States, 1980

Funding: Intramural
Project Officer: Judith A. Kasper
Division of Beneficiary Studies

Description: The purpose of this project is to develop an overview report of major findings from the National Medical Care Utilization and Expenditure Survey. Data for the Nation and the Medicare and Medicaid populations will be presented, covering sociodemographic characteristics, access to primary care, and use and expenditures for all types of health services. Special studies will include use and expenditures by the "crossover" population (persons covered by both Medicare and Medicaid), and levels of Medicaid use and expenditures taken from a four-State sample of Medicaid claims data.

Status: Completion of a draft report is expected during 1985.

Title XIX Data Development

Acquisition and Analysis of State Medicaid Data

Project No.: 500-81-0030
Period: June 1981 - June 1985
Funding: $ 2,142,382
Award: Contract
Contractor: SysteMetrics, Inc.
4520 East-West Highway
Suite 600
Bethesda, Md. 20814
Project Officer: David K. Baugh
Division of Program Studies

Description: This project is acquiring person-level data on Medicaid enrollment, claims, and providers from State Medicaid Management Information Systems (MMIS). Uniform files are being created to compare State trends. Data collection includes five States (California, Georgia, Michigan, New York, and Tennessee) for 1980 through 1982. These data are being used to support a number of program activities including:

- Analysis of refugee health and expenditures.
- A study of high-cost infants.
- Analysis and evaluation for selected demonstration projects.
- A series of Medicaid analytic notes.
- The Medicaid program evaluation.

These data will also be linked to Medicare records to produce information on issues related to enrollees of both Medicaid and Medicare programs.

Status: Through December 1984, person-level enrollment, claims, and provider data were obtained from State MMIS. System documentation was reviewed and code maps were produced to translate raw data into "uniform" files. Initial data processing and "early return" tabulations were completed for 1980 through 1982 data from Michigan and New York and for 1980 and 1981 from California. An analytic note entitled, "Recipients of Covered Services Among Medicaid Enrollees: Michigan and New York, 1981," HCFA Pub. No. 03188, is available from the Office of Research and Demonstrations.

Medicaid Tape-to-Tape: Data and Analysis

Project No.:	HCFA-500-84-0037
Period:	June 1984 - June 1986
Funding:	$ 2,132,969
Award:	Contract
Contractor:	SysteMetrics, Inc. 104 W. Anapamu Street Santa Barbara, Calif. 93101
Project Officers:	David K. Baugh and Penelope Pine Division of Program Studies

Description: This project continues the development and implementation of a Medicaid person-level data set from five State Medicaid Management Information Systems (MMIS) (California, Georgia, Michigan, New York, and Tennessee). This effort will acquire data on enrollment, claims, and providers for 1983 and 1984. These data will be used to create uniform files, provide descriptive reports, support analysis and evaluation, and develop methodology for on-line data base management. This project provides a continuum of 5 years of uniform Medicaid data for the conduct of analysis of program management, evaluation of policy alternatives, and feedback to States in the area of Medicaid financing.

Status: As of December 1984, project staff are planning for the acquisition and processing of person-level enrollment, claims, and provider data that will be obtained from State MMIS. New "early return" tabulations will be designed to include data on mortality and diagnosis. A number of analytic studies are planned.

Program Management

State Medicaid Information Center Project

Project No.:	18-P-97923/3-03
Period:	January 1981 - November 1985
Funding:	$ 719,018
Award:	Grant
Grantee:	National Governors' Association Center for Policy Research Hall of the States Washington, D.C. 20001
Project Officer:	Aileen Pagan-Berlucchi Division of Program Studies

Description: This grant project monitors changes in State Medicaid program policy and disseminates information on these changes through a survey-based report updated every 6 months. The National Governors' Association (NGA) also contracts with research groups outside the Federal Government to produce research reports on special topics of current interest in the area. The project group at NGA works closely with State Medicaid directors and other program personnel in developing research topics and data collection priorities.

Status: Key products from this project include:

- Medicaid Survey Report: "Recent and Proposed Changes in State Medicaid Programs" from 1982 on, co-published with the Intergovernmental Health Policy Project.
- "Medicaid: Freedom of Choice" - A review of waiver applications submitted under Section 2175 of the Omnibus Budget Reconciliation Act of 1981, August 1982.
- "Volume Purchasing of Goods and Services in State Medicaid Programs," October 1982.
- "Medicaid Program Changes, State-by-State Profiles," May 1982.
- "Controlling Medicaid Costs: Second Surgical Opinion Programs," November 1982.
- "Catalog of State Medicaid Program Changes - The State Medicaid Program Information Center," December 1982.
- "Reducing Excessive Utilization of Medicaid Services: Recipient Lock-in Programs," June 1983.
- "Nursing Homes, Hospitals, and Medicaid: Reimbursement Policy Adjustments, 1981-1982," March 1983.
- "An Analysis of Responses to the Medicaid Home- and Community-Based Long-Term Care Waiver Program," June 1983.
- "Public Programs Financing Long-Term Care," January 1983.

Establish and Manage a Medicaid Information and Assistance Project

Project No.: 18-C-98220/3-02
Period: September 1984 - November 1985
Funding: $ 120,000
Award: Cooperative Agreement
Awardee: American Public Welfare Association
1125 Fifteenth Street, Suite 300
Washington, D.C. 20005
Project Officer: Aileen Pagan-Berlucchi
Division of Program Studies

Description: This project is designed to analyze and make recommendations on information and assistance needs and resources from the perspective of the State Medicaid agencies. The three distinct but interrelated objectives are:

- To design, implement, and evaluate new mechanisms for matching the information and assistance needs of State Medicaid agencies with resources that are available to meet these needs.

- To continue to monitor the information and assistance needs of State Medicaid agencies, as well as the resources available to meet these needs.

- To coordinate activities with the Health Care Financing Administration and the State Medicaid Directors' Association aimed at identifying and altering problematic policies, procedures, and practices that pose as barriers to the effective administration of the Medicaid program.

Status: This cooperative agreement is newly awarded and is in its developmental phase.

State Legislative Resource and Information Center on Health Care Financing

Project No.: 19-P-98266/8-02
Period: June 1983 - May 1986
Funding: $ 547,017
Award: Grant
Grantee: National Conference of State Legislatures
1125 Seventeenth Street, Suite 1500
Denver, Colo. 80202
Project Officer: Vic McVicker
Division of Hospital Experimentation

Description: This project will demonstrate that a centralized source of information on State and Federal health care financing initiatives and programs will assist the Nation's State legislatures, as well as the Health Care Financing Administration, by contributing to a more informed decisionmaking process. A number of mechanisms will be used to establish and disseminate information from the resource center. These include surveys of State legislatures, publications, seminars, direct technical assistance, and response to requests for specific information.

Status: During the first quarter of the second year of the project, activities funded by the grant have included:

- Onsite technical assistance to the Wisconsin, Wyoming, and Montana legislatures.
- Sponsorship of six programs at the National Conference of State Legislators Annual Meeting, July 1984.
- Responses to 136 information requests from 39 States and the District of Columbia on health care issues.
- The final drafts of a major report and an article on State cost-containment initiatives are being prepared for publication.

Intergovernmental Health Policy Project

Project No.:	18-P-98148/3-02
Period:	March 1982 - November 1985
Funding:	$ 1,305,696
Award:	Grant
Grantee:	George Washington University Rice Hall, 6th Floor Washington, D.C. 20052
Project Officer:	Aileen Pagan-Berlucchi Division of Program Studies

Description: This grant project describes current health law, policy, and legislative actions affecting State Medicaid programs. The Intergovernmental Health Policy Project (IHPP) compiles and disseminates information on State health activites, including new developments in the Medicaid cost-containment area. IHPP serves as a clearinghouse on State legislative actions. Through this clearinghouse function, IHPP distributes a monthly newsletter, "State Health Notes," detailing the current status and pending changes in the medical program. IHPP also disseminates special summaries of topical issues in the Medicaid program through the "Legislative Snapshot" report series and periodic background reports.

Status: Key products from this project include:

- Medicaid Survey Report: "Recent and Proposed Changes in State Medicaid Programs" from 1982 on, co-published with the National Governors' Association.
- "State Health Notes," a newsletter published 10 times each year.
- Background reports (for example, "Medigap: Issues and Update, 1982," "Alternatives to Institutional Care for the Elderly: An Analysis of State Initiatives," September 1981, and "Creating the Medical Marketplace: Selective Contracting in California's Medi-Cal Program, 1983."
- "Legislative Snapshot" (on such topics as nursing homes and Medicaid).
- "Focus On..." supplement to "State Health Notes," new series on special feature items within specific States.
- "DRG's and Medicaid: Recent State Actions," June 1984.
- "Status of Major State Policies Affecting Hospital Capital Investment," February 1984.

Economic and Clinical Outcomes of Three Drug Cost-Containment Strategies in Medicaid

Project No.: 18-C-98496/1
Period: July 1984 - July 1985
Funding: $ 203,718
Award: Cooperative Agreement
Awardee: Harvard Medical School
Department of Social Medicine and Health Policy
643 Huntington Avenue
Boston, Mass. 02115
Project Officer: Penelope L. Pine
Division of Program Studies

Description: The primary objectives of this study are to determine the impact of several State cost-containment strategies on drug expenditures implemented in 1981, the use of essential versus nonessential medications, and certain clinical outcomes. The principal research activities will consist of obtaining, condensing, and analyzing drug claims and other data from Medicaid Management Information Systems of several States. The research design will involve a number of time series analyses in both study and comparison States.

Status: As of December 1984, three different types of Medicaid drug cost-containment strategies have been selected for study. The policy interventions and study locations are:

- Statewide limits on the number of prescriptions allowed per Medicaid patient in New Hampshire.
- Imposition of $1.00 copay for each prescribed drug in Vermont.
- Combination of strict benefit cap and copayment in Arkansas.

Research on Competitive Forces Driving Medicare Utilization

Project No: 17-C-98522/9-01
Period: September 1984 - September 1986
Funding: $ 199,306
Award: Cooperative Agreement
Awardee: SRI International
333 Ravenswood Avenue
Menlo Park, Calif. 94025
Project Officer: Judith Sangl
Division of Reimbursement and Economic Studies

Description: The major objective of this project is to analyze how various factors affect Medicare beneficiaries' utilization of and expenditures for services. These factors include: ownership of supplemental health insurance policies, beneficiaries' knowledge of the Medicare program and of the supplemental policies they own, and the extent for which beneficiaries are treated on assignment by physicians. Data sources include: a detailed 1982 survey of a random sample of Medicare beneficiaries in six States (California, Florida, Mississippi, New Jersey, Washington, and Wisconsin), copies of the insurance policies owned by beneficiaries in this sample, and complete Medicare utilization records for this sample from 1980 to 1982.

Status: The project has been delayed until the Medicare Automated Data Retrieval System is available for use.

The Impact of Medicaid Home and Community-Based Waiver Services for the Mentally Retarded in Maine

Project No: 11-C-98605/1-01
Period: July 1984 - July 1985
Funding: $ 48,438
Award: Cooperative Agreement
Awardee: Maine Department of Human Services
221 State Street
Augusta, Maine 04333
Project Officer: Gerald S. Adler
Division of Beneficiary Studies

Description: The study assesses the first year of a program which provides home-and community-based care to 200 mentally retarded persons in Maine, in lieu of institutional care. Program implementation and administration will be compared with the intended program design. Costs of services and quality of life for waiver participants will be compared with those of comparable controls. Multiple regression will be used to estimate program effects while controlling for other characteristics of the participants and care settings.

Status: Sampling and instrumentation have been completed.

Develop the Technology of Aide Sharing into a Transferable Form for Use by Home Health Agencies to Reduce Home Health Costs

Project No.: 17-C-98480/3-02
Period: August 1984 - July 1985
Funding: $ 109,811
Award: Cooperative Agreement
Awardee: HCR, Inc.
2121 L Street, NW.
Washington, D.C. 20036
Project Officer: Doris Sneeringer
Health Services Studies Office

Description: This project is authorized under the Small Business Innovation Development Act of 1982 (Public Law 97-219). The objective of this program is to support the development of products and services by small firms in the health care sector. This project is intended to allow HCR to explore the market potential of providing the management support services needed to develop management tools for use by home health agencies in implementing the shared-aide concept. The shared-aide concept uses a home health aide to serve several clients who reside within a restricted geographical area and whose needs for services are not continuous. Several visits in the same day to the same client could be involved. Special management techniques are needed for the recruitment and training of aides, monitoring and supervision of aides, establishing priorities and scheduling of services, and maintenance of time records for billing purposes.

Status: Phase I of this project, completed in March 1984, established the feasibility of reducing home health costs by using the shared-aide concept. Under Phase II, HCR's systems for performing job task analysis, demand-based scheduling, aide training, recordkeeping, and accounting will be contained in an instructional manual accompanied by optional software packages. HCR began working on Phase II in October 1984, and is currently conducting preliminary research on State-by-State home health aide training requirements and reimbursement methodologies. The findings obtained from this research will be used in developing the manual needed to help home health agencies implement the shared-aide concept.

Policy Centers

Brandeis University Health Policy Research Consortium

Project No.: 15-C-98526/1-01
Period: March 1984 - February 1989
Funding: $ 1,375,000
Award: Cooperative Agreement
Awardee: Brandeis University Heller Graduate School
415 South Street
Waltham, Mass. 02254
Project Officer: Allen Dobson
Office of Research

Description: The Brandeis University Health Policy Research Consortium (HPRC) is primarily supporting the research that will be required as background for preparation of the Reports to Congress mandated in the legislation (Public Law 98-21) enacting the new Medicare prospective payment system (PPS). The Brandeis HPRC includes the Boston University School of Medicine; the Center for Health Economics Research, Cambridge, Mass.; and The Urban Institute, Washington, D.C. These institutions provide expertise in the areas of health services delivery issues, physician payment alternatives, and Medicaid and long-term care policy options, as well as microsimulation and data processing capabilities. The Brandeis Consortium is conducting research activities that will examine:

- The reimbursement of sole community hospitals.
- The appropriate treatment of uncompensated-care costs, and adjustments for large teaching hospitals in rural areas.
- The advisability and feasibility of physician DRG's and other research in support of physician reimbursement reform.
- The feasibility of eliminating separate urban and rural payment rates.
- The method under which the excepted hospitals can be paid on a prospective basis.
- The feasibility and desirability of an all-payer prospective payment system.

In addition, the Brandeis Consortium is sponsoring the PPS Technical Advisory Panel which convenes quarterly to advise the Director of the Office of Research on research activities related to the mandated PPS Reports to Congress.

The Brandeis Consortium is conducting these additional activities that are not directly related to the mandated reports:

- Short-term technical assistance projects.
- Other reimbursement reform studies; in particular, the adjusted average per capita cost (AAPCC) study.
- Selected projects for the Office of Demonstrations and Evaluations, including seven multiyear projects on demonstration issues.

Status: Each year under the cooperative agreement, the Brandeis HPRC and the Health Care Financing Administration (HCFA) jointly develop an agenda of specific topics and projects to conduct. The Center is currently in its first year of operation. To date, numerous projects have been planned or have begun on research issues related to the mandated PPS Reports and on demonstration issues. For example, the research activities on uncompensated-care costs and on sole community hospitals and rural tertiary hospitals have been incorporated in project reports submitted to HCFA.

The Rand/University of California, Los Angeles, Health Financing Policy Research Center

Project No.: 15-C-98489/9-01
Period: March 1984 - April 1989
Funding: $ 1,525,000
Award: Cooperative Agreement
Awardee: The Rand Corporation
1700 Main Street
Santa Monica, Calif. 90406
Project Officer: Richard Yaffe
Division of Hospital Experimentation

Description: The primary responsibility of the Rand/University of California, Los Angeles (UCLA) Research Center is to provide expert consultation in planning, implementing, and evaluating demonstrations and experiments in the Medicare and Medicaid programs. Among the tasks to be performed are:

- Developing literature reviews.
- Developing options papers and recommendations concerning the planning, design, and implementation of demonstrations and evaluations.
- Providing technical assistance to demonstration and evaluation grantees and contractors.
- Reviewing and making recommendations on demonstrations, research or evaluation designs, and deliverables.
- Carrying out small-scale evaluations.
- Holding and documenting discussions or meetings with appropriate experts and/or representatives of various constituents to deal with specific issues.
- Preparing syntheses of the results of Health Care Financing Administration demonstrations and evaluations and related experience.

In addition, the Center is supporting the research that will be required for preparation of the Reports to Congress mandated in the legislation (Public Law 98-21) enacting the Medicare prospective payment system (PPS). These research activities will examine:

- The impact of PPS on classes of hospitals, beneficiaries, other payers, and other providers.
- The method under which rehabilitation hospitals and units can be paid on a prospective basis.
- The advisability of the provision of cost of care information to public and private payers.

- The appropriateness of outlier payments, and the applicability of severity of illness, intensity of care, or other modifications to the diagnosis-related groups system.

- The feasibility of an admissions volume adjustment.

Status: Each year under the cooperative agreement, the Center and the Health Care Financing Administration jointly develop an agenda of specific topics and projects to conduct. The Center is currently in its first year of operation. To date, numerous projects have been planned or have begun on demonstration and evaluation issues and on program research issues. For example, two short-term technical assistance projects regarding quality-of-care assessment and cost estimation in demonstrations have been completed, as well as several smaller technical assistance, review, and training projects. In addition, substantial progress has been made in planning and initial work on several large, multiyear projects in both areas.

Program Analysis

Study of the Quality and Effectiveness of Experimental Fixed-Price Medicare Part A Intermediary Contracting

Project No.: 500-83-0030
Period: June 1983 - January 1985
Funding: $ 203,595
Award: Contract
Contractor: Abt Associates
55 Wheeler Street
Cambridge, Mass. 02138
Project Officer: William J. Sobaski
Division of Reimbursement and Economic Studies

Description: This project will examine the impact of experimental fixed-price contracting for intermediary services in two States, New York and Missouri. The contractor will assess the procurement processes, the transition periods, and the resultant states of readiness for operations. Analyses will be made of claims processing and program outlays, provider and beneficiary services, and the quality of audit and settlement services in the initial year of operations on a fixed-price basis. Recommendations will be provided for a methodology suitable for use in evaluating other fixed-price contracting arrangements.

Status: This project was initiated June 27, 1983. Site visits began in September 1983. Initial descriptive and analytic reports flow began in December 1983 and continue on a bimonthly basis. The final research design report has been received and accepted. Preliminary reports on the procurement processes, beneficiary services impact, auditing impact, contract changes, and an evaluation methodology were received. The final report is expected Spring 1985.

Health Services Utilization Study

Project No.: 18-P-98442/9-01
Period: September 1983 - September 1986
Funding: $ 616,268
Award: Grant
Grantee: The Rand Corporation
1700 Main Street
Santa Monica, Calif. 90406
Project Officer: James Lubitz
Division of Beneficiary Studies

Description: The purpose of this study is to examine whether high use rates of certain procedures in selected geographic areas reflect inappropriate overuse and, to a lesser extent, whether low procedure rates in other areas reflect underuse. Three procedures that show large geographic variation, consume a significant amount of resources, and are likely to be overused have been selected for study from six candidate procedures. Medicare Part B claims data from 12 areas in 8 States were used to study geographic variation. A high- and low-rate area will be selected from the 12 areas for each procedure. The records of 100 physicians for each procedure in each area will be studied to determine the indications for performing each procedure. Then the indications for each procedure, as abstracted from the medical records, will be compared with the indications drawn up by an expert panel of physicians. The hypothesis is that the indications in the high-rate areas will be less generally accepted--suggesting inappropriate overuse.

Status: Work on this study has already begun under funding from three private foundations. Medicare Part B data have been gathered and are being analyzed. Literature reviews on the indications for three procedures have been completed. Procedures chosen for study are coronary angiography, diagnostic upper gastrointestinal endoscopy, and carotid endarterectomy, with work on data gathering on indications for coronary angiography likely to begin soon. Physicians have met to rank indications for five procedures, and a successful pilot test to gather data from physicians and hospitals on coronary angiography and upper gastrointestinal endoscopy has been completed.

Use of Medicare Services by Disabled Enrollees Under 65 Years of Age

Funding: Intramural
Project Director: James Lubitz
Division of Beneficiary Studies

Description: More research has been devoted to the Medicare aged population than to the population of disabled enrollees under 65 years of age. Yet disabled enrollees comprise about 10 percent of Medicare enrollment, and Medicare expenditures for them have been rising faster than for aged enrollees. To increase available knowledge of the Medicare disabled population, analyses are being carried out on patterns of health services used by the disabled. In particular, this population is being analyzed by type of disability award, i.e., disabled worker, adult disabled in childhood (ADC), or disabled spouse. Also, the aged (over 65 years of age) Medicare population who were formerly disabled Medicare beneficiaries are being studied.

Status: Results from the first study of the disabled indicate that per capita reimbursement for the disabled are equal to that of the aged and that disabled women exceed men in per capita reimbursement. The majority (82 percent) of the Medicare disabled population are disabled workers, 14 percent are adults disabled in childhood (ADC), and 4 percent are disabled spouses. Per capita reimbursement in 1978 for ADC's was considerable lower ($345) than for disabled workers ($924) or disabled spouses ($1,051). Aged Medicare beneficiaries who were formerly disabled Medicare beneficiaries have 1.9 times the per capita reimbursement of other Medicare beneficiaries in the same age group. Preliminary results also indicate that need for care, as indicated by use of Medicare services, does not diminish with time on the disability program. A second study is being developed linking the Social Security Administration's Disability History File to Medicare records. When the link is completed, analyses will examine the relationship of such factors as reason for disability, length of time disabled, and return to work to health care use.

Use of Services by the Dually Entitled (Crossovers)

Funding: Intramural
Project Director: Alma McMillan
Division of Beneficiary Studies

Description: More than 13 percent of the aged population are covered by both Medicare and Medicaid. In view of the proposed and recently enacted changes in both programs, the health care use of the dually entitled is of special interest.

Status: A study of Medicare use by the dually entitled (crossovers), published in the Summer 1983 issue of the Health Care Financing Review, found that per capita Medicare reimbursement for the crossovers was 50 percent higher than for other enrollees and that the mortality rate was also 50 percent higher. A second study on the aged crossovers used the National Medical Care Utilization and Expenditure Survey to examine the utilization of noninstitutionalized persons and their reimbursements made by Medicare, Medicaid, and other sources and the relation of health status, education, and income to health service use. Many of the findings of the earlier study, such as higher per capita costs and higher mortality for the crossovers, were confirmed even though the institutionalized were excluded. Thus, the noninstitutionalized aged population covered by Medicare and Medicaid is in substantially poorer health than other noninstitutionalized aged persons covered only by Medicare. This study was published in the Winter 1984 issue of the Health Care Financing Review. A third study on the crossovers is planned using person-level data from Medicare and Medicaid in selected States. It will focus on patterns of long-term care and hospital use by the crossovers. Plans for linking Medicare and Medicaid data for crossovers are proceeding.

Studies of Medicare Use Before Death

Funding: Intramual
Project Officers: Jerry Riley and James Lubitz
Division of Beneficiary Studies

Description: These studies examine the use of Medicare services in the last years of life. This information is needed because of the large percentage of Medicare expenditures for enrollees in their last year and because of the interest in hospice care as an alternative kind of care for the terminally ill.

Status: The first study showed that 28 percent of Medicare expenditures are for persons in their last year, that persons who die receive more than six times the reimbursements of other enrollees, and that expenditures in the last year are concentrated in the last few months. The study also showed that the relative share of Medicare expenditures going to enrollees in their last year has changed little from 1967 to 1979. The results of this study were published in Health, United States, 1983, the annual report from the Secretary of the Department of Health and Human Services to the President and Congress, and in the Spring 1984 issue of the Health Care Financing Review. Knowledge gained in this study is being applied in the administration and evaluation of the hospice benefit. In addition, data on Medicare reimbursements for the dying in conventional settings will be used as comparison data to evaluate the cost and utilization experience under the new hospice benefit. A second study is underway to analyze Medicare use by cause of death. The study uses cause of death data from the National Center for Health Statistics linked to Medicare data. Medicare expenditures will be examined by cause of death (e.g., cancer, heart attack), time before death, type of service, and age and sex. Preliminary results indicate there is considerable variation in Medicare reimbursements in the last year of life, by cause of death.

Post-Surgical Mortality Among the Aged for Common Operations

Funding: Intramural
Project Officer: Jerry Riley
Division of Beneficiary Studies

Description: About 2.5 million hospital stays for surgery for Medicare enrollees occur annually. Much of this surgery is to some extent discretionary. Thus, to the extent that some of these surgical procedures could be avoided, some of the associated mortality might be reduced. Using 1979-80 data, this study examines mortality up to a year after eight common operations--cholecystectomy, prostatectomy, inguinal hernia repair, cataract removal, arthroplasty of the hip (both total hip replacement and other arthroplasty), reduction of fracture of the femur, and coronary bypass--comprising about one-quarter of operations for aged Medicare enrollees.

Status: Results show that the risk of dying increases markedly with age and that patients operated on for prostatectomy and hip repair (other than total hip replacement) have higher than average mortality for up to a year following the operation. Results also show lower post-surgical mortality in the West for several operations: transurethral prostatectomy, coronary bypass, reduction of fracture of the femur, and arthroplasty of the hip (other than total hip replacement). The study provides new data on the risks of coronary bypass surgery among the elderly, showing that the risk of dying in the 1.5 months after bypass surgery is 6 percent, and that the risk is 1.7 times greater for women than men.

The Relation of Surgical Volume and Other Factors to Mortality After Surgery

Funding: Intramural
Project Director: Jerry Riley
Division of Beneficiary Studies

Description: Do hospitals that do more surgeries have better outcome in terms of mortality than other hospitals? Studies of the general population have found better outcomes for some operations in hospitals with a high volume of surgeries. This study investigates whether there is such a relation in the Medicare population for 8 operations--prostatectomy; reduction of fracture of the femur; resection of intestine; cholecystectomy; repair of inguinal hernia; coronary bypass, and total and other hip repair.

Status: A preliminary draft report has been completed and a working paper entitled, "Outcomes of Surgery in the Medicare Population: The Relation of Surgical Volume and Other Factors to Mortality," is available. Hospitals doing a high volume of coronary bypass and resection of intestine had lower mortality for these operations. Some evidence of a volume-mortality relationship was also found for prostatectomy, cholecystectomy, total hip replacement, and other arthroplasty of hip, although lower mortality may be associated with volume of any type of surgery.

Rehospitalization After Surgery Among Medicare Enrollees

Funding: Intramural
Project Director: Jerry Riley
Division of Beneficiary Studies

Description: This study examines patterns of rehospitalization for Medicare enrollees after seven common operations. Patterns of rehospitalization by age, sex, type of hospital, and time after operation (up to 9 months) will be investigated. Reasons for rehospitalization will be described. In addition, the question of whether hospitals doing more operations have better outcomes in terms of lower rates of rehospitalizations will be studied.

Status: Preliminary results show considerable variation among procedures with respect to rehospitalization within both 7 days and 30 days following discharge from the surgical stay. Rehospitalization rates following surgery were also higher than the average for the Medicare population for all seven procedures, for at least 9 months following surgery. Regional patterns were also evident, with lower rates of rehospitalization in the Northeast and higher rates in the South.

Study of High-Cost Infants Under Medicaid

Funding: Intramural
Project Director: Jerry Riley
Division of Beneficiary Studies

Description: This study will focus on infants who incur high levels of reimbursements under the Medicaid program. Michigan data for 1980 and 1981 from the Health Care Financing Administration's "Tape-to-Tape" project will be used, with more States to be added if data become available in time. The study will focus on costs, diagnoses, services, incidence (in Medicaid), and mortality rate for such infants.

Status: Extensive data processing activities are nearly completed and analyses will begin soon. Preliminary data indicate that, in 1982, there were about 500 hospitalizations for premature birth in Michigan, with average hospital costs of about $11,000.

Changes in the Distribution of Medicare Expenditures

Funding: Intramural
Project Director: Jerry Riley
Division of Beneficiary Studies

Description: A large portion of Medicare expenditures has historically been concentrated on a small number of beneficiaries who are heavy users of services. The question often arises as to whether expenditures under the program have become more or less concentrated over time among small numbers of high-cost individuals. This study will compare distributions of Medicare reimbursements for 1969, 1975, and 1982. The data will be analyzed for persons dying and for survivors in 1975 and 1982. The distribution of 1980 expenditures for the non-Medicare population, as reported in the National Medical Care Expenditure and Utilization Survey, will also be examined.

Status: Preliminary data indicate that Medicare reimbursements have become slightly less concentrated among all enrollees in recent years.

Medicare and Medicaid Data Book

Funding: Intramural
Project Directors: Martin Ruther and Aileen Pagan-Berlucchi
Division of Program Studies

Description: This report provides descriptive statistics on the organization and operation of the Medicare and Medicaid programs. It compares the two programs' beneficiary charactertistics, use of medical services, expenditures, financing, and administration. The 1984 edition will include a new two-part section describing Medicare policy as applied to the control of hospital care costs and analyzing changes in the factors that determine Medicaid expenditures. The report includes appendices that provide sources of information contained in the book and names and addresses of program officials. This report provides a resource for public officials, researchers, policy analysts, and users and providers of health care.

Status: The Medicare and Medicaid Data Book, 1983 has been published and is available only from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402, Stock No. 017-070-00399-1, price $4.75. The 1984 edition is projected to be published in Winter 1985.

Program Statistics Series Reports and Health Care Financing Notes

Funding: Intramural
Project Directors: Charles Helbing and Martin Ruther
Division of Program Studies

Description: These statistical reports and notes describe, measure, and evaluate Medicare program benefits, program initiatives, program operation, and performance. The annual Medicare benefit reports are mandated by the Social Security Law. The other program reports and notes are either directly mandated by Congress, reflect current topical issues of the day, or reflect current legislative and/or policy initiatives and directives.

Status: The following reports have either been recently completed or have been sufficiently developed so that usable data are available:

- "Medicare: Use and Charges for Accommodation and Ancillary Services in Short-Stay Hospitals by Diagnosis-Related Groups, 1981."
- "Medicare: Use of Short-Stay Hospital Services by Aged Inpatients, Annual Summary, 1981."
- "Medicare: Use and Cost of Short-Stay Hospital Services by Beneficiaries with the Principal Diagnosis of Alzheimer's Disease, 1981."
- "Medicare: Liability of Medicare Enrollees Using Physician Services, 1980."
- "Medicare: Use and Cost of Short-Stay Hospital Services by Beneficiaries with the Principal Diagnosis of Diabetes, 1981."
- "Medicare: Use and Cost of Hospital Outpatient Services, 1982."
- "Medicare: Use and Cost of Home Health Agency Services, 1983."
- "Medicare: Use and Cost of Long-Stay Hospital Services, 1982."
- "Medicare: Use and Cost of Short-Stay Hospital Services, 1982."
- "Medicare: Use of Skilled Nursing Facilities, 1980."
- "Medicare: Use of Home Health Services, 1980."

Program Evaluation

Medicaid Short-Term Evaluation

Project No.: HHS-100-82-0038, Task Order 5
Period: March 1983 - January 1984
Funding: $ 125,000
Award: Contract
Contractor: Urban Systems Research and Engineering, Inc.
2067 Massachusetts Avenue
Cambridge, Mass. 02140
Project Officer: Gerald S. Adler
Division of Beneficiary Studies

Description: This is the second in a series of evaluative studies focusing on the effects of the Omnibus Budget Reconciliation Act of 1981 (OBRA) and subsequent legislation on the Medicaid program. The first study prepared the groundwork by specifying evaluation issues, data, and methods. The current study uses available data to address these policy issues, focusing particularly on eligibility changes, utilization by the institutionalized and dually eligible groups, and general program trends. The third study, the Medicaid Program Evaluation, will go beyond the short-term study by including post-OBRA data.

Status: The final report entitled, "Short-Term Evaluation of Medicaid: Selected Issues, is available through the National Technical Information Service (accession No. PB84-196427) or as a Health Care Financing Administration Grants and Contract Series report, from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402, Stock No. 017-060-00169, Price $7.00.

Medicaid Program Evaluation

Period: September 1983 - September 1986
Project Officer: Gerald S. Adler
Division of Beneficiary Studies

Description: The Office of Research is conducting a 3-year project to assess the changes made in the Medicaid program as a result of recent legislation. The Medicaid Program Evaluation focuses principally on program changes since the Omnibus Budget Reconciliation Act of 1981, an Act which considerably increased State flexibility in determining eligibility, reimbursement, and coverage under the program. The evaluation addresses the implementation and impact of selected changes in the program to provide knowledge for policy assessment and future legislative change. It is focused on a select list of issues and policy questions.

Status: Three contracts were awarded on September 30, 1983, to conduct the evaluation studies:

- La Jolla Management Corporation, with subcontractor SysteMetrics, is studying home- and community-based care and incentives for family care.
- Abt Associates, with subcontractors Health Economics Research and Compass Consulting, is studying hospital reimbursement changes.
- James Bell Associates, with subcontractors Syracuse University, Urban Institute, and National Governors' Association, is studying freedom of choice, eligibility, cost-sharing, Federal financial participation, and 1983 legislation, and preparing the annual synthesis.

Interim reports on each task and an interim synthesis report will be available in mid-1985.

Medicaid Program Evaluation: Cluster I

Project No.: 500-83-0056
Funding: $ 953,595
Award: Contract
Contractor: La Jolla Management Corporation
11426 Rockville Pike
Rockville, Md. 20852

Description: This project addresses two tasks as part of the Medicaid Program Evaluation. The first deals with the home and community-based waiver program. Under Section 2176 of the Omnibus Budget Reconciliation Act of 1981, States under a waiver may institute a variety of home- and community-based services to individuals who "but for" the waiver would be in long-term care institutions. The following questions will be addressed: Has the program reduced institutionalization? Has the program reduced costs? Has cost shifting occurred from other programs, specifically Titles XX of the Social Security Act and III of the Older Americans Act? Can we identify the elements of a successful program? The second task deals with financial incentives for family care. Several States provide financial support through direct payments or tax incentives to family members to encourage their assistance to their elderly relatives. The major questions are: What programs are in operation? What have been their costs and savings? Who are the beneficiaries of such programs and what are their characteristics? What are the characteristics of functionally limited persons living in the community that permit them to avoid institutionalization? What are the characteristics of successful programs?

Status: The contract was awarded September 30, 1983. Interim reports will be available in mid-1985.

Medicaid Program Evaluation: Cluster II

Project No.: 500-83-0057
Funding: $ 763,629
Award: Contract
Contractor: Abt Associates
55 Wheeler Street
Cambridge, Mass. 02138

Description: This project addresses inpatient hospital reimbursement as part of the Medicaid Program Evaluation. To help bring hospital costs under control, the Omnibus Budget Reconciliation Act of 1981 granted the States new flexibility in the establishment of inpatient hospital reimbursement methodologies. Major questions are: What responses have States made to the options permitted by Federal law? Have reductions in expenditures resulted? Specifically, what has been the impact of the California program? Two other State programs will be studied for comparison. What have been the effects on recipients and providers of care? Have costs been shifted to private payers? To what degree and in what ways has the implementation of Medicare prospective reimbursement had an impact on State Medicaid programs?

Status: The contract was awarded September 30, 1983. Interim reports will be available in mid-1985.

Medicaid Program Evaluation: Cluster III

Project No.: 500-83-0058
Funding: $ 1,449,479
Award: Contract
Contractor: James Bell and Associates, Inc.
1700 North Moore Street, Suite 1622
Arlington, Va. 22209

Description: This project addresses several issues as part of the Medicaid Program Evaluation. The first is freedom of choice waivers. Under Section 2175 of the Omnibus Budget Reconciliation Act (OBRA) 1981, States may institute a variety of programs to reduce costs by limiting the provision under Medicaid which guarantees freedom of choice of provider. Major questions are: How have the States responded to this provision? Have there been program savings? How have access to and quality of health care been affected? The second is eligibility. OBRA 1981 contained several changes which directly and indirectly reduced the number of persons eligible for Medicaid. Major questions are: How have the States responded to these provisions? How have eligibility changes in related programs (Aid to Families with Dependent Children and Supplemental Security Income) affected Medicaid enrollment? How have entitlement and expenditures been affected? How has the reduction in Medicaid coverage affected other assistance programs, out-of-pocket expenditures, and costs to hospitals and other payers? The third is cost-sharing. Under the Tax Equity and Fiscal Responsibility Act of 1982, States are permitted to impose nominal copayments, with certain limitations, to reduce program outlays, and to instill cost consciousness on the part of the recipients. Major questions are: How have the States responded? What has been the effect of copayments on utilization and costs? The fourth is Federal financial participation. OBRA 1981 provides for the reduction of Federal matching funding for 3 years, beginning October 1, 1982, subject to certain exemptions. Major questions are: Which States were exempted from the reductions and for what reasons? How much did the Federal Government save? How did the States adjust to reduced funding? Fifth, as legislation in 1983, 1984, and 1985 adds further changes to Medicaid, the evaluation will attempt to address the implications of these new provisions. The final task of the project will be to provide for the preparation of an annual interpretation, a summary, and synthesis of evaluation results.

Status: The contract was awarded September 30, 1983. Interim reports will be available in mid-1985.

Medicare Automated Data Retrieval System

Project No.: 500-83-0034
Period: August 1983 - September 1984
Funding: $ 146,805
Award: Contract
Contractor: Inter Systems Inc.
7640 Little River Turnpike
Annandale, Va. 22003
Project Officer: Paul Lichtenstein
Division of Health Systems and Special Studies

Description: The Medicare Automated Data Retrieval System (MADRS) will reorganize the Medicare bill and payment records to improve the accessibility of the data. The Office of Research and Demonstrations has a continual need for 100-percent data by geographic region or on individual Medicare beneficiaries or providers for carrying out research studies and for evaluating demonstrations. The current 100-percent bill or payment record files are organized in weekly batches in health insurance claim (HIC) number sequence. To find records for any individual beneficiary, provider, or geographic region, it is necessary to search through all the tapes. MADRS proposes to sort the 100-percent bill payment record file into yearly files and then by geographic region (county) and HIC number. The MADRS system will be indexed by county, provider, and HIC number. Using MADRS, it would be possible to quickly locate the portion of the files where the required data is located and retrieve it for research and demonstration studies.

Status: The development phase of MADRS is complete. Data for 1980 through 1983 will be processed for retrieval by September 1986.

Studies Evaluating Medicaid Home- and Community-Based Services: A Report to Congress

Funding: Intramural
Project Director: Gerald Adler
Division of Beneficiary Studies

Description: The Orphan Drug Act of 1982, Public Law 97-414, Section 6(b), directs the Secretary to "report the results of studies currently evaluating home- and community-based health services, and any recommendations for legislative action which might improve the provision of such services, to the Congress." This intramural project will produce that report, based on the studies of the waiver program conducted as part of the Medicaid Program Evaluation.

Status: The Medicaid Program Evaluation studies were begun in October 1983. A draft Congressional report has been prepared for submission to the Congress.

End-Stage Renal Disease

National Kidney Dialysis and Kidney Transplantation Study

Project No.: 95-P-97887/0-03
Period: January 1981 - September 1984
Funding: $ 776,750
Award: Grant
Grantee: Battelle Memorial Institute
4000 N.E. 41st Street
Seattle, Wash. 98105
Project Officer: Carl Josephson
Office of Research

Description: The purpose of this study is to analyze the impact of alternative types of therapy on end-stage renal disease (ESRD) patients. Patient outcomes are measured in terms of the patient's quality of life, quality of care, cost of care, and rehabilitation status. Data collection instruments included direct patient interviews, facility-based medical records abstracts, completion of patient medical-expense diaries, and the Health Care Financing Administration program data records from entitlement forms, provider certification records, facility survey files, facility cost reports, facility and provider reimbursement records, and other medical information files.

Status: Data based on 850 ESRD patients receiving care under four different types of therapy from 11 renal dialysis centers and facilities were collected during the first 18 months of the study. The next 20 months were spent in the editing and analysis of the basic data and the preparation and publication of 25 supporting documents and 17 major papers. In general, the study found that patients are not randomly assigned to different treatment modalities and that case-mix differences do affect patient outcomes. There were significant differences in the measures of quality of care and quality of life by type of therapy, and these differences persisted after adjusting for differences in patient case mix. Also, significant declines in labor-force participation were associated with onset of the renal disease. In the study, only about one-half of the patients used rehabilitation services, and their use of services varied significantly across types of treatment modalities. Among the patients in the study for whom peritoneal dialysis is most appropriate, the choice of continuous cycling peritoneal dialysis (CCPD) represents an increasingly attractive alternative to continuous ambulatory peritoneal dialysis (CAPD) or intermittent peritoneal dialysis, since the patients were found to have a lower incidence of peritonitis, fewer hospital admissions, and fewer days of hospitalization. Both short- and long-term complications are associated with organ transplantation. Serious complications are more likely to be present among ESRD patients who have experienced a failed transplant than among patients who have successfully functioning allografts. These differences, however, are not attributable to patient case-mix differences because the two patient transplant groups do not differ with regard to age, sex, race, education, and primary disease diagnosis.

The major papers were:

- "Case Mix, Treatment Modalities, and Patient Outcomes: Results of the National Kidney Dialysis and Kidney Transplantation Study."
- "A Comparative Assessment of the Quality of Life of Patients on Four Treatment Modalities."
- "Functional Impairment, Work Disability, and the Availability and Use of Rehabilitation Services by Patients with Chronic Renal Failure."
- "Labor Force Participation Among ESRD Patients."
- "Health Services Utilization and Disability Days: Indicators of the Quality of Patient Care Among ESRD Patients."
- "Premorbid and Post-Treatment Functional Limitations Among Patients with Chronic Renal Failure."
- "Complexities in the Treatment of ESRD: Economic Efficiency and Treatment Modality Prescription."
- "The Demographic Characteristics of the National Kidney Dialysis and Kidney Transplantation Study: A Comparison With the ESRD Population."
- "The Use of Rehabilitation Services by Patients With Chronic Renal Failure."
- "Peritonitis, Hospital Admissions, and Days Hospitalized Among Patients on CAPD and CCPD: A Comparative Assessment."
- "Extrarenal Complications Among Kidney Transplantation Recipients."
- "Travel Costs Incurred by ESRD Patients."
- "National Policies for Treatment of End-Stage Renal Disease."
- "A Comparative Assessment of the Quality of Life of Successful Kidney Transplant Patients According to Source of Graft."
- "ESRD Patient Preferences for Dialysis and Transplantation."
- "A Comparison of the Utilization of Hospital Services Among ESRD Patients on Four Treatment Modalities."
- "The Financial Status of ESRD Patients."
- "National Kidney Dialysis and Kidney Transplantation Study: A Summary of Results."

The final project report is expected to be published during 1985 as a Health Care Financing Administration Special Report.

Design of a Demonstration and Assessment of Competitive Health Insurance Proposals in the End-Stage Renal Disease Program

Project No.: 14-P-98275/3-01
Period: April 1983 - March 1986
Funding: $ 879,694
Award: Grant
Grantee: The Urban Institute
2100 M Street, N.W.
Washington, D.C. 20037
Project Officer: Mel Bulkley
Division of Health Systems and Special Studies

Description: This project will determine the feasibility of demonstrations to test competitive financing approaches in the end-stage renal disease (ESRD) program, with possibilities including:

- Competitive bidding.
- Global capitation covering all medical care costs.
- Partial capitation covering only outpatient ESRD services.
- Voucher payment allowing patients to share in the financial savings of cost-reducing shifts.

If competitive approaches are feasible, the Urban Institute will develop the demonstration model and an evaluation design. The evaluation will consider:

- Structure of the experimental treatments.
- Methods to ensure randomization.
- Determination of appropriate capitation amounts.
- Design of a reinsurance system.
- Estimate of sample sizes.

Status: The grantee assisted the Health Care Financing Administration in the development of its intramural end-stage renal disease competitive bidding demonstration. It has submitted a detailed plan for the evaluation of that demonstration. Urban Institute is collecting baseline data and will analyze the data relating to case-mix, quality, and patient-choice factors. Reports have been submitted on the competitive bidding models. These reports provide the conceptual background and consider practical implementation issues of the various bidding models.

Developing Incentive Systems to Increase the Supply of Cadaveric Kidneys for Transplants

Project No.: 14-C-98333/1-02
Period: June 1983 - June 1985
Funding: $ 297,414
Award: Grant
Grantee: Brandeis University
415 South Street
Waltham, Mass. 02254
Project Officer: Paul W. Eggers
Division of Beneficiary Studies

Description: Using survey methodologies, this project will evaluate alternative approaches to increasing the participation of nongovernmental actors in organ procurement programs. The end result of the research will be a set of Health Care Financing Administration policy recommendations designed to improve the effectiveness of organ procurement networks and so increase the number of kidneys available for transplantation.

Status: The cooperative agreement was initiated June 1983. The methodology entails surveys of major participants in the organ procurement process. These include hospital administrators, directors of nursing, intensive care unit nurses, and neurosurgeons. Each group of these professionals was administered a questionnaire designed to elicit information concerning their knowledge and personal opinions about organ procurement, perceived barriers to organ procurement, and potential recommendations for improving the organ procurement process. In addition, donor families and the general public were interviewed to collect information on public attitudes toward organ procurement. Data collection has been completed and the project is in the analysis phase.

Relative Effectiveness and Cost of Transplantation and Dialysis in End-Stage Renal Disease

Project No.: 14-P-98372/5-01
Period: September 1983 - September 1988
Funding: $ 1,110,383
Award: Grant
Grantee: University of Michigan
Department of Epidemiology
109 Observatory Street
Ann Arbor, Mich. 48109
Project Officer: Carl Josephson
Division of Program Studies

Description: This study will perform a comprehensive assessment of the cost effectiveness of end-stage renal disease treatment under different treatment modalities, an assessment of the impact of Cyclosporin A on transplant success, and a life-table analysis of risk factors for patient and graft survival. The study will use data from the Michigan Kidney Registry, supplemented by survey information and medical record abstractions. Because of the design of the study, it is anticipated that the project will demonstrate the utility of a longitudinal, patient-specific data system for policy decisionmaking at the Federal level.

Status: The project is in the data collection phase. The baseline cohort has been identified and the construction and pretesting of the data collection instruments have been completed. Baseline data for the quality-of-life study is being collected from 500 patients.

Organ Donor Education Project

Project No.: 14-P-98437/0-01
Period: September 1983 - March 1985
Funding: $ 41,410
Grantee: Oregon Donor Program
P.O. Box 532
Portland, Oreg. 97207
Project Officer: Melvin Bulkley
Division of Health Systems and Special Studies

Description: The purpose of the demonstration is to test whether the number of organ donors would be increased by the use of videotapes aimed at increasing public awareness of the need for organs. Two tapes were produced--a public education tape shown to applicants for drivers' licenses in 60 Oregon Department of Motor Vehicle (DMV) Offices, and an informational tape to train DMV personnel to promote organ donation.

Status: Scripts for the two audiovisual tapes and filming have been completed. The tapes were exhibited in DMV offices from July through September 1984. An evaluation design was developed with assistance from the Health Care Financing Administration and is being implemented by the grantee.

Costs, Outcomes, and Competiton in the End-Stage Renal Disease Program

Project No.: 18-P-98056/3
Period: August 1981 - September 1984
Funding: $ 407,096
Grantee: The Urban Institute
2100 M Street, N.W.
Washington, D.C. 20037
Project Officer: William Sobaski
Division of Reimbursement and Economic Studies

Description: This project will aid in the overall assessment of the End-Stage Renal Disease (ESRD) program by studying three aspects:

- The determinants of the total cost of the program.
- Some measures of the health outcomes produced by the program.
- Alternative ways of organizing and improving the services.

Particular attention will be given to the effects of competition on the cost and quality of care among facilities in an area.

Status: Three major papers have been produced thus far under this grant:

- "Pro Competitive Health Insurance Proposals and their Implications for the ESRD Program."
- "Competition and Efficiency in the ESRD Program."
- "Financial Incentives and Policy Goals of the End-Stage Renal Disease Program."

The first paper concludes that there are numerous ways to induce more competitive behavior in the delivery of ESRD service, especially maintenance dialysis, although there are significant implementation problems with some strategies. The second paper concludes that analysis of cost alone cannot determine appropriate reimbursement levels, because that determination requires a prior political decision of the appropriate level of amenities. The third paper concludes that the precise legislative intent regarding the goals of the ESRD program is ambiguous, particularly to treatment objectives. In December 1984, a report of recommendations for revising ESRD system central files was received. The final report is expected by Summer 1985.

End-Stage Renal Disease Nutritional Therapy Study

Period: September 1984 - August 1993
Project Officer: Melvin Bulkley and Henry Krakauer
Division of Health Systems and Special Studies and Division of Beneficiary Studies

Description: In accordance with the Congressional mandate (Public Law 96-499), this study will seek to determine (1) the extent to which the commencement of nutritional therapy in early renal failure (utilizing controlled protein substances) can retard or arrest the progression of the disease resulting in substantive deferment of dialysis, and (2) the administrative, financial, and other aspects of making nutritional therapy generally available under Medicare. The study will be conducted jointly by The National Institute of Health (NIH) and the Health Care Financing Administration. Initiation of full-scale clinical trials will be preceded by a developmental phase and a pilot test.

Status: The developmental phase began in September 1984. NIH has awarded six clinical centers to conduct the clinical trials and the preliminary phases. The clinical centers are:

Division of Nephrology and Hypertension
Harbor-University of California at Los Angeles
Medical Center
1000 W. Carson Street
Torrance, Calif. 90509

Veterans Administration Medical Center
Building 3
Iowa City, Iowa 52240

Department of Pharmacology and Experimental Therapeutics
Johns Hopkins University
725 N. Wolfe Street
Baltimore, Md. 21205

New England Medical Center
Box 784
171 Harrison Avenue
Boston, Mass. 02111

Renal Division
Brigham and Women's Hospital
75 Francis Street
Boston, Mass. 02115

Vanderbilt University Medical Center
Division of Nephrology
Room B-2214 MCN
Nashville, Tenn. 37232

A data coordinating center has also been awarded:

Department of Biostatistics
The Cleveland Clinic Foundation
9500 Euclid Avenue
Cleveland, Ohio 44106

The Steering and Planning Committee for the study is developing the protocol and operations manual for the pilot test and clinical trials.

Severity of Illness in End-Stage Renal Disease Population in Northern Florida

Project No.: 14-C-98696/4-01
Period: September 1984 - September 1986
Funding: $ 509,356
Award: Cooperative Agreement
Awardee: University of Florida
Grinter Hall
Gainesville, Fla. 32610
Project Officer: Paul Eggers
Division of Beneficiary Studies

Description: The purpose of this study is to develop and test measures of severity of illness that predict resource consumption levels in the end-stage renal disease (ESRD) program. These measures will be based on the acute physiology and chronic health evaluation (APACHE) system, which was developed to measure therapeutic effort and resource costs in intensive care units. Two components of APACHE, the therapeutic intervention scoring system (TISS) and the acute physiology score (APS) will be adapted to the special characteristics of the ESRD patient receiving dialysis. The TISS and APS will then be used to measure ESRD case mix and resource consumption.

Status: This cooperative agreement was initiated in September 1984. It is in the design phase.

Comparison of Quality of Life of End-Stage Renal Disease Patients

Project No.: 14-C-98642/5-01
Period: September 1984 - September 1986
Funding: $ 50,453
Award: Cooperative Agreement
Awardee: University of Minnesota Family Study Center
1114 Social Sciences
Minneapolis, Minn. 55455
Project Officer: Henry Krakauer
Division of Beneficiary Studies

Description: The objective of this study is to evaluate the quality of life of patients on different therapeutic regimens for end-stage renal disease. The following groups will be compared:

- Transplant recipients randomly allocated to conventional immunosuppression.
- Transplant recipients randomly allocated to immunosuppression with cyclosporine.
- Patients on center hemodialysis.
- Patients on continuous ambulatory peritoneal dialysis.
- A historical control of patients who received transplants in 1970-1973.

Clear-cut differences in survival do not necessarily distinguish among the above treatment modalities. Comparative quality of life is, therefore, an important criterion.

Status: The data for this study have been collected in the course of other studies. Analysis has begun, but results are not yet available.

Waiver for the Northwest Kidney Center, Seattle, to be Reimbursed Directly for Providing Home Dialysis Training Services

Project No.: 95-C-98485/0-01
Period: November 1984 - October 1987
Award: Cooperative Agreement
Awardee: Northwest Kidney Center
700 Broadway
Seattle, Wash. 98118
Project Officer: Marla Aron
Division of Health Systems and Special Studies

Description: The Northwest Kidney Center (NKC) is conducting a pilot test of a home dialysis training program. Under this program, NKC will provide home dialysis training services to 6-10 patients per year at two facilities (Central Washington Hospital in Wenatchee and Olympic Peninsula Kidney Center in Bremerton) and will also provide training in the homes of one to two hepatitis B antigen positive patients per year. The home dialysis training will be provided for 2-3 weeks depending on the individual patient. Training will be on a 5-day-week basis with 3 weekly hemodialyses, or continuously in the case of continuous ambulatory peritoneal dialysis. The goal is to show that a regionalized home dialysis training program will increase the number of patients choosing to dialyze at home.

Status: As of December 31, 1984, the project has been operational for 2 months and is in its startup phase.

Captitation Payment System for All End-Stage Renal Disease Services

Project No.: 95-C-98497/9-01
Period: January 1985 - December 1989
Funding: $ 380,000
Award: Cooperative Agreement
Awardee: El Camino Hospital District Corporation
2500 Grant Road
Mountain View, Calif. 94042
Project Officer: Marla Aron
Division of Health Systems and Special Studies

Description: This project will develop and test a competitive capitation program under which capitation payments would cover all Medicare benefits to end-stage renal disease (ESRD) patients (including transplants). The awardee will negotiate a capitation rate with the Health Care Financing Administration (HCFA) at 95 percent of the estimated Medicare fee-for-service cost. A delivery system similar to a health maintenance organization will be developed and will include case management for ESRD patients, patient incentives, physicians' incentives and risk taking, preferred provider contracts, and quality assurance measures.

Status: The awardee is preparing to negotiate capitation rates and stop-loss provisions with HCFA.

Comparative Analysis of the Cost and Outcomes of Kidney Transplants

Project No.: 14-C-98564/0-01
Period: July 1984 - July 1987
Funding: $ 900,000
Award: Cooperative Agreement
Awardee: Battelle Human Affairs Research Center
4000 NE. 41st Street
Seattle, Wash. 98105
Project Officer: Henry Krakauer
Division of Beneficiary Studies

Description: This is a multicenter observational study of the impact of cyclosporine on renal transplantation. A sample of 300 patients contributed by eight major centers experienced in the use of cyclosporine will be studied in depth. Detailed information on outcomes (mortality, complications, disability) and costs will be collected on this sample and analyzed in terms of major prognostic factors. In addition, extensive data of a medical or biologic and of a sociologic nature will be obtained. The representativeness of the sample will be validated by comparison with the universe of patients treated with cyclosporine for whom more limited information is available in the Health Care Financing Administration Medical Information System data base.

Status: A collaboration with the scientific studies committee of the American Society of Transplant Surgeons has been formalized and a working group of physicians to advise on and guide the biomedical component of the study has been empaneled and has met twice. The first draft of supplementary questionnaires designed to gather medical data has been prepared and is under review by the medical working group. Participating transplant centers have been enrolled and subcontracts for data acquisition are under negotiation.

Assessment of Emerging Technologies for the Treatment of End-Stage Renal Disease

Funding: Intramural
Project: Henry Krakauer
Director: Division of Beneficiary Studies

Description: The purpose of this project is to evaluate the utility of new treatment methodologies emerging into clinical practice in end-stage renal disease. Data currently available in the Health Care Financing Administration Medical Information System data base and supplementary information collected as needed will be used to analyze outcomes (mortality, morbidity, disability, and cost) associated with the use of the new methodologies. Prognostic factors that significantly affect the outcomes will be identified and their impact measured. Finally, projections of the consequences of adoption of the methodologies will be made to obtain estimates of their medical impacts and of their effects on program expenditures.

Status: The impact of the use of cyclosporine in cadaver-donor renal transplants performed in 1982 and 1983 has been analyzed in terms of the effects on graft and patient survival and on inpatient costs. The drug has a marked beneficial effect on graft retention rates. The effect on inpatient costs is not yet clear because patient-management practices are still undergoing rapid changes. Data are being collected on donor-specific transfusions administered to recipients of living-donor renal transplants, to be analyzed as above. A collaboration with the National Continuous Ambulatory Peritoneal Dialysis registry is under negotiation for the purpose of assembling a comprehensive data base to permit similar analyses.

Medicare End-Stage Renal Disease Experience

Funding: Intramural
Project Director: Paul Eggers
Division of Beneficiary Studies

Description: This study examines overall trends in the Medicare end-stage renal disease (ESRD) program. Changes in incidence, prevalence, and patient survival will be explored. In addition, changes in patient characteristics such as age, sex, race, and diagnosis will be documented. Medicare reimbursements for ESRD patients will be analyzed as well, including hospital costs, physician costs, and outpatient dialysis costs. Special analyses will be done on transplant patients.

Status: The following papers and reports have been generated from this study:

- "Life Expectancy and Use of Services by Persons With End-Stage Renal Disease Enrolled in Medicare," Paper presented at the American Public Health Association Annual Meeting, New York, 1979.

- "Analyses of Indicators of Case-Mix Differences Between Freestanding Facility and Hospital-Based Medicare ESRD Patients," Working Paper No. OR-33, Office of Research and Demonstrations, Health Care Financing Administration, May 1982.

- "Trends in Incidence, Prevalence, Survival, and Reimbursement in Medicare ESRD Patients," Working Paper No. OR-40, Office of Research and Demonstrations, Health Care Financing Administration, April 1982.

- "Medicare Program Experience With End-Stage Renal Disease," Paper presented at the New York Academy of Sciences, New York, January 1983.

- "Uses of the End-Stage Renal Disease Medical Information System for Epidemiological Research," Paper presented at the National Nephrology Foundation, New York, January 1983.

- "The Medicare Experience With End-Stage Renal Disease: Trends in Incidence, Prevalence, and Survival," Health Care Financing Review, Spring 1984.

- "Cost-Effectiveness of Kidney Transplantation: An Analysis of the Pay-Back Time for Transplant Patients," Proceedings of the 19th National Meeting of the Public Health Conference on Records and Statistics, Washington, D.C., August 1983.

- "Trends in Medicare Reimbursement for End-Stage Renal Disease: 1974-1979. Health Care Financing Review, Fall 1984."

- "Recent Trends in ESRD Research," Paper presented at the Annual Meeting of the National Organization of State Kidney Programs, Washington, D.C., December 7, 1984.

- "ESRD Data Sources, Uses and Limitations," Paper presented at the Annual Meeting of the Renal Physicians Association, Scottsdale, Ariz., February 24, 1985.

End-Stage Renal Disease Annual Report to Congress

Funding: Intramural
Project Director: Paul Eggers
Division of Benficiary Studies

Description: The Office of Research and Demonstrations (ORD) has the responsibility for producing three sections included in each year's report to Congress (Public Law 95-292). These are: End-stage renal disease (ESRD) patient morbidity, ESRD patient mortality, and ancillary hospital costs.

Status: ORD has produced the three sections above for the following reports:

- 1981 ESRD Annual Report to Congress, HCFA Pub. No. 82-02144.
- 1982 ESRD Annual Report to Congress, Medicare Annual Report, Fiscal Year 1981, HCFA Pub No. 02156.
- 1983 ESRD Annual Report to Congress, submitted for departmental approval.
- 1984 ESRD Annual Report to Congress, submitted for departmental approval.

Urban Clinics

Urban Health Clinics Demonstration

Project No.: 500-81-0048
Period: September 1981 - December 1985
Funding: $ 891,089
Award: Contract
Contractor: Technassociates, Inc.
1700 Rockville Pike, Suite 200
Rockville, Md. 20852
Project Officer: John F. Meitl
Division of Health Systems and Special Studies

Description: The Rural Health Clinics Act of 1977 (Public Law 95-210) mandated that the Department of Health and Human Services conduct demonstrations in urban medically underserved areas to test the relative advantages and disadvantages of cost-based and fee-for-service reimbursement for physician-directed clinics that employ physician assistants or nurse practitioners. The demonstration involves approximately 36 clinics in California and Tennessee. An appropriate definition of medically underserved areas will also be established by the Public Health Service.

Status: The second annual meeting of the participating clinics was held October 1984. The meeting was attended by personnel from eight clinics in California and eight clinics in Tennessee. As of December 31, 1984, 40,082 claims were received for processing by the Health Care Financing Administration, Office of Direct Reimbursement, and $1,086,977 was paid to participating clinics. The evaluation contractor, Arthur D. Little, Inc., has completed the case study site visit and Technassociates, Inc., will conduct the quality-of-care site visit in 1985.

Evaluation of the Urban Health Clinics Demonstration

Project No.: 500-82-0025
Period: September 1982 - August 1986
Funding: $ 806,666
Award: Contract
Contractor: Arthur D. Little, Inc.
Acorn Park
Cambridge, Mass. 02140
Project Officer: Spike Duzor
Division of Health Systems and Special Studies

Description: The purpose of this contract is to evaluate the Urban Health Clinics Demonstration (Project No. 500-81-0048). The evaluation will focus on use, cost, and quality of services.

Status: The data resources report and literature review were completed January 1983. The research design report and final report were delayed because of delays in implementation of the demonstration. The design report was submitted in December 1983 and the final report is expected in August 1986.

Technology Costs

Technology Assessment for Insurance Coverage Decisions

Funding: Brandeis University Health Policy Research Consortium
(See page 174)
Project Officer: Joel Broida
Division of Reimbursement and Economic Studies

Description: The Massachusetts Institute of Technology, a part of the Brandeis University Health Policy Research Consortium, conducted a two-part study involving technology assessment for insurance coverage decisions. The first part of the study looked at the decisionmaking process used by Medicare and major Blue Cross/Blue Shield plans in determining coverage for new technologies. Two samples of technological innovations were drawn. The first consisted of a sample of 11 procedures that were studied in depth. The second sample consisted of 75 procedures less intensively studied. The second part of the study sought to identify the factors and weights related to the coverage decisions and to examine how they influence the coverage recommendations.

Status: The results of this study have been published by the Brandeis Consortium in the Journal of Health Care Technology, Fall 1984. The paper entitled, "The Process of Evaluation of Medical Technologies for Third-Party Coverage" addresses some of the problems and issues encountered in the determination of safety and effectiveness for a variety of medical technologies. It also describes how the evidence was obtained and utilized by different organizations in the determination of and the recommendations for or against coverage and reimbursement.

Clinical Social Worker

Medicare Clinical Social Worker Demonstration

Project No.:	500-82-0053
Period:	September 1982 - December 1985
Funding:	$ 441,345
Award:	Contract
Contractor:	SRI International 333 Ravenswood Avenue Menlo Park, Calif. 94025
Project Officer:	Shelagh Smith Division of Health Systems and Special Studies

Description: The Omnibus Reconciliation Act of 1980 (Public Law 96-499) mandated that the Department of Health and Human Services conduct a demonstration to determine the effects of making the services of clinical social workers more generally available under Medicare. The demonstration will allow direct reimbursement to clinical social workers for their services rather than through a physician or clinic. This contract is for the design and implementation of the direct reimbursement demonstration.

Status: In the initial phase of the project, the contractor has identified the demonstration sites and carriers who process claims and collect information. Southern California is the experimental site with Transamerica Occidental as carrier, and Northern California is the control site with Blue Shield of California as carrier. Initiation of services by clinical social workers began January 1984. Major tasks accomplished include establishing administrative claims-processing systems to be implemented by the Medicare carrier in the test site; training, marketing, and registering 1,500 clinical social workers in Southern California; and implementing direct reimbursement in seven Southern California counties where 1.2 million Medicare beneficiaries live. As of December 1984, approximately 400 beneficiaries had seen clinical social workers participating in the demonstration.

Other Coverage

Study of Medicare-Funded Heart Transplants

Project No.: 500-81-0051
Period: September 1981 - December 1984
Funding: $ 1,626,294
Award: Contract
Contractor: Battelle Human Affairs Research Centers
4000 N.E. 41st Street
Seattle, Wash. 98105
Project Officer: Joel Broida
Division of Reimbursement and Economic Studies

Description: This project is an evaluation of the scientific, economic, ethical, and social consequences of Medicare coverage for heart transplants. The study will evaluate the survival rates of heart transplant patients and the total costs of transplantation. It will additionally perform an analysis of organ donation, examine the field of organ procurement, and attempt to determine the legal and ethical implications of transplantation while controlling for perceived quality of life.

Status: The final report has been received and is currently being reviewed prior to its release.

Evaluation of the Medicare Mental Health Demonstration

Project No.: 100-80-0148
Period: September 1980 - June 1985
Award: Contract
Contractor: Macro System, Inc.
8630 Fenton Street
Silver Spring, Md. 20910
Co-Project Officers: Sharman Stephens
Office of the Assistant Secretary for Planning and Evaluation
Tony Hausner
Division of Long-Term Care Experimentation

Description: This project evaluates the utilization and cost implications of a demonstration encompassing 40 sites that waived the physician supervision requirements for Medicare reimbursement to mental health centers. Study areas will focus on assessment of impact of this waiver on mental health services, utilization patterns, overall cost to the Medicare program, and administrative and operational capacity of the participating mental health centers. The Office of the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, is funding this project and administering it jointly with the Health Care Financing Administration.

Status: The research design was completed in August 1981, and the study is underway. A final report is expected in June 1985.

Medigap Study of Comparative Effectiveness of State Regulations

Project No.: 500-81-0050
Period: September 1981 - May 1984
Funding: $ 1,258,757
Award: Contract
Contractor: SRI International
333 Ravenswood Avenue
Menlo Park, Calif. 94025
Project Officer: Judith Sangl
Division of Reimbursement and Economic Studies

Description: This study will evaluate the effectiveness of various State regulatory approaches for health insurance sold to the elderly. It contains both a consumer survey of Medicare beneficiaries and an industry survey of the companies who sell insurance to them. It will be conducted in six States.

Status: The final report of the consumer survey was submitted in Fall 1983. The report found that three State actions impacted on the purchase of higher quality policies. They are:

- Establishing miminum benefit requirements.
- Setting mimimum loss ratios.
- Distributing consumer guides.

Although State regulations seem to have less impact on sales abuse, two strategies--distributing consumer guides and issuing press releases when companies or agents are found guilty of misrepresentation--appear to have some beneficial effect. Finally, the distribution of consumer guides was associated with greater consumer knowledge of Medicare or of the policies purchased. The final report of the consumer survey was available in Fall 1983. The industry survey was completed May 1984. The Report to Congress mandated by Public Law 96-265, which is based largely on this study, is forthcoming.

Evaluation of Obstetrical Access Pilot Project

Project No.: 11-P-97578/9-02
Period: March 1980 - August 1984
Funding: $ 203,370
Award: Grant
Grantee: Department of Health Services
714 P Street
Sacramento, Calif. 95814
Project Officer: Tony Hausner
Division of Long-Term Care Experimentation

Description: The purpose of this grant is to conduct an evaluation of the Obstetrical Access Pilot Project (Project No. 11-P-97223/9-03) which was completed in March 1983. The project tested the hypothesis in 10 clinical sites that the provision of early access to obstetrical services for low-income pregnant women would reduce subsequent morbidity of both infants and mothers. Services included health education, nutrition, and psychosocial assessments in addition to prenatal, delivery, and postpartum services.

Status: The research design was completed in December 1981. An interim report was prepared in December 1982 for submission to the State legislature. A key finding is that the project reduced the rate of low-birth-weight babies. The final report is expected in early 1985.

Impact of Psychological Intervention on Health Care Utilization and Costs: A Prospective Study

Project No.: 11-C-98344/9-02
Period: September 1983 - September 1988
Funding: $ 955,000
Award: Cooperative Agreement
Awardee: Hawaii State Department of
Social Services and Housing
P.O. Box 339
Honolulu, Hawaii 96809
Project Officer: Andrew K. Solarz
Division of Health Systems and Special Studies

Description: The goal of this demonstration is to conduct a prospective study on the island of Oahu, Hawaii, of approximately 3,124 randomly selected Medicaid high-health-care utilizers who will be provided short-term psychosocial intervention counseling. A private-sector, health maintenance organization group on the island also will be studied. The impact of the treatment on health care utilization and costs will be evaluated. The subcontractor, the Foundation for Behavioral Health of San Francisco, Calif., will implement and evaluate the study.

Status: Space has been leased on the island of Oahu for a counseling center, known as the Biodyne Center. Five clinical therapists have joined the staff and have completed special training in the clinic's form of short-term therapy. Training manuals and videotapes are in production. Client intake began in May 1984.

New Jersey Mobile Intensive Care System

Project No.: 95-P-98352/2-01
Period: November 1983 - October 1986
Award: Grant
Grantee: New Jersey State Department of Health
CN 363
Trenton, N.J. 08625
Project Officer: Cynthia K. Mason
Division of Hospital Experimentation

Description: The purpose of the Mobile Intensive Care Unit (MICU) system is to demonstrate the cost effectiveness of New Jersey's approach to provision of emergency, advanced life-support services. Paramedics and advanced life-support equipment are transported in the MICU vehicle while emergency patient transportation will continue to be provided by volunteer ambulance squads.

Status: Starting November 1, 1983, Medicare, Medicaid, and other third-party payers began covering MICU charges as an outpatient service. For Medicare, the charge is paid under Part B, unless the patient is admitted to a hospital. Under such circumstances, the MICU charge is included on the inpatient bill. In addition, the Health Care Financing Administration agreed to retroactively reimburse New Jersey hospitals under Part A for MICU services rendered during the period January-October 1983.

Evaluation of the Impact of Second Opinions for Elective Surgery

Project: 500-78-0047
Period: September 1978 - October 1984
Funding: $ 2,225,791
Contractor: Abt Associates, Inc.
55 Wheeler Street
Cambridge, Mass. 02138
Project Officer: Alan Friedlob
Division of Long-Term Care Experimentation

Description: The objective of this evaluation is to determine the effect of formal second-opinion programs on surgery rates, surgical costs, and the health of patients who forego surgery as a result of obtaining a second opinion. The basis of the evaluation is two voluntary Medicare Second Surgical Opinion Programs (SSOP) in New York City and Detroit, the State of Massachusetts' mandatory Medicaid SSOP, and the Health Care Financing Administration's (HCFA) public information, second surgical opinion program.

Status: Based on an interim report, the Office of Research and Demonstrations, HCFA, prepared a report to Congress on the desirability of waiving Medicare cost sharing for voluntarily sought second surgical opinions. This study is summarized in a brief report in the September 1982 issue of the Health Care Financing Review. The final report presents an analysis of the direct effects of the Massachusetts SSOP on patients' surgery decisions and provides evidence that the mandatory Medicaid SSOP results in reduced surgery rates for targeted procedures and is cost effective. The study also concludes that there is little potential for a voluntary Medicare SSOP to result in cost savings for the Medicare program. The final report will be available Spring 1985.

Foot Care Coverage Study

Funding: Intramural
Project Directors: Alvin Freedman
Division of Reimbursement and Economic Studies

Description: Public Law 96-499, Section 958(g), directs the Secretary of the Department of Health and Human Services to conduct a study involving a comprehensive analysis of the cost effects of alternative approaches to improving coverage under Title XVIII of the Social Security Act for the treatment of various types of foot conditions. The study has involved meetings and discussions with professional and Federal experts; staff reviews of literature and relevant statistical information; a Federal Register notice soliciting information and comments from the public; a survey of State Plans for Medical Assistance; an independent study by the Center for Health Services and Policy Research at Northwestern University; and actuarial estimates of the costs of eliminating certain presently excluded or specifically restricted types of expenses for treatment of foot conditions. The study will examine present Medicare benefits for the treatment of foot conditions as specified in the law and its implementing regulations and manuals. Possible ways for improving coverage will be identified, and the effects these changes could have on beneficiary health status and on the pattern of sources now used for financing foot care treatment will be considered.

Status: The report has been drafted and is under review and is expected to be submitted to the Congress in Spring 1985.

Registered Dietitians in Home Care

Funding: Intramural
Project Director: Marni Hall
Division of Reimbursement and Economic Studies

Description: Section 958 of Public Law 96-499, the Omnibus Budget Reconciliation Act of 1980, directs the Department of Health and Human Services to conduct a study of "the circumstances and conditions under which services furnished by registered dietitians should be covered as a home health benefit under Title XVIII of the Social Security Act." The study has three objectives:

- To assess Medicare beneficiaries' needs for direct clinical counseling by registered dietitians in the home.
- To explore alternative methods for coverage and reimbursement.
- To estimate utilization rates and costs for the alternative methods of coverage and reimbursement.

Status: The draft report is currently under review by the Health Care Financing Administration. It will be submitted to the Secretary of the Department of Health and Human Services in early 1985.

Home Respiratory Therapy Services

Funding: Intramural
Project Director: Marni Hall
Division of Reimbursement and Economic Studies

Description: Section 958 of Public Law 96-499, the Omnibus Budget Reconciliation Act of 1980, requires that the Department of Health and Human Services conduct "a study of the circumstances and conditions under which services furnished with respect to respiratory therapy should be covered as a home health benefit under Title XVIII of the Social Security Act." This study evaluates these issues and examines the present "state of the art" in respiratory therapy and the current availability of respiratory therapy services. It also examines the medical and economic ramifications of expanding Medicare benefits to include those home services provided by respiratory therapists.

Status: The draft report is currently under review by the Health Care Financing Administration. It will be submitted to the Secretary of the Department of Health and Human Services in early 1985.

Alcoholism Services Demonstration Projects

Period: September 1981 - January 1986
Project Officer: Andrew K. Solarz
Division of Health Systems and Special Studies

Description: The following six projects are a collaborative demonstration between the Office of Research and Demonstrations, Health Care Financing Administration, and the National Institute on Alcohol Abuse and Alcoholism, Public Health Service. These demonstration projects are designed to test the feasibility and cost effectiveness of providing limited coverage for alcoholism treatment services given in freestanding (nonhospital) treatment centers. Each project is uniformly using the following service limits for Medicare and/or Medicaid services:

- Alcohol detoxification--No limit on episodes.
- Inpatient treatment--Up to 30 days per year.
- Outpatient treatment--Up to 45 visits per year.

Alcoholism Services under Medicare: Connecticut Demonstration

Project No.: 95-P-97968/1-04
Funding: $ 324,046
Grantee: Connecticut Alcohol and Drug Abuse Commission
999 Asylum Avenue
Hartford, Conn. 06105

Status: Coverage of services in Connecticut was initiated July 1, 1982. The State has 12 providers participating in the demonstration in Medicare only. Provider staff have been trained in billing and cost-reporting procedures. A beneficiary and referral centers, demonstration-awareness program has been developed within the target area. The project is in its fourth year of funding. Through November 1984, 445 Medicare clients entered treatment at the 12 provider sites.

Alcoholism Services under Medicare and Medicaid: Illinois Demonstration

Project No.: 95-P-97971/5-04 (Medicare)
Funding: $ 148,018
Award: Grant
Grantee: Department of Alcoholism and Substance Abuse
901 Southwind Road
Springfield, Ill. 62703

Project No.: 11-P-97972/5-04 (Medicaid)
Funding: $ 168,252
Grantee: Department of Public Aid
931 East Washington Street
Springfield, Ill. 62703

Status: Coverage of services in Illinois was initiated July 1, 1982. The State has 12 providers participating in the demonstration in both Medicare and Medicaid. Provider staff have been trained in billing and cost-reporting procedures. A beneficiary and referral centers, demonstration-awareness program has been developed within the target area. Illinois has developed a prospective rate for alcoholism services that is being used in the project. The project is in its fourth year of funding. As of November 1984, a total of 122 Medicare clients and approximately 415 Medicaid beneficiaries entered treatment at the 12 sites.

Alcoholism Services under Medicare and Medicaid: Michigan Demonstration

Project No.: 95-P-97975/5-04 (Medicare)
Funding: $ 54,176
Award: Grant
Grantee: Office of Substance Abuse Services
Department of Public Health
3500 North Logan
Box 30035
Lansing, Mich. 48909

Project No.: 11-P-97976/5-04 (Medicaid)
Funding: $ 258,793
Award: Grant
Grantee: Medical Services Administration
Department of Social Services
300 South Capital Avenue
Lansing, Mich. 48909

Status: Coverage of services in Michigan was initiated July 1, 1982. The State has 24 providers participating in the demonstration in both Medicare and Medicaid. Provider staff have been trained in billing and cost-reporting procedures. A beneficiary and referral centers, demonstration-awareness program has been developed within the target area. The project is in its fourth year of funding. As of November 1984, a total of 570 Medicare clients and approximately 1,542 Medicaid beneficiaries entered treatment at the 24 sites.

Alcoholism Services under Medicare and Medicaid: New Jersey Demonstration

Project No.: 99-P-97973/2-04
Funding: $ 386,806
Award: Grant
Grantee: Division of Medical Assistance and Health Services
325 East State Street
Trenton, N.J. 08625

Status: Coverage of services in New Jersey was initiated August 1982 for Medicare and in October 1982 for Medicaid. The State has 24 providers participating in the demonstration in both Medicare and Medicaid. Provider staff have been trained in billing and cost-reporting procedures. A beneficiary and referral centers, demonstration- awareness program has been developed within the target area. The project is in its fourth year of funding. As of November 1984, a total of 480 Medicare clients and 1,440 Medicaid beneficiaries entered treatment at the participating 24 sites.

Alcoholism Services under Medicare and Medicaid: New York Demonstration

Project No.: 99-P-97979/2-04
Funding: $ 383,739
Award: Grant
Grantee: Division of Medical Assistance
Department of Social Services
40 North Pearl Street
Albany, N.Y. 12243

Status: Coverage of services in New York was initiated July 1, 1982. The State has 15 providers participating in the demonstration in both Medicare and Medicaid. Provider staff have been trained in billing and cost-reporting procedures. A beneficiary and referral centers, demonstration-awareness program has been developed within the target area. The project is in its fourth year of funding. As of November 1984, a total of 239 Medicare clients and approximately 574 Medicaid beneficiaries entered treatment at the 15 sites.

Alcoholism Services under Medicare: Oklahoma Demonstration

Project No.: 95-P-97983/6-04
Period: September 1981 - December 1985
Funding: $ 574,872
Award: Grant
Grantee: American Indian Institute
University of Oklahoma at Norman
555 Constitution Avenue
Norman, Okla. 73037

Status: Coverage of services in Oklahoma was initiated July 1, 1982. The State have 19 providers participating in the demonstration in Medicare only. Provider staff have been trained in billing and cost-reporting procedures. A beneficiary and referral centers, demonstration-awareness program has been developed within the target area. The project is in its fourth year of funding. As of November 1984, a total of 263 Medicare clients entered treatment at the 19 sites.

Evaluation of the Alcoholism Services Demonstration

Project No.: 500-83-0023
Period: April 1983 - December 1986
Funding: $ 2,644,996
Award: Contract
Contractor: Lawrence Johnson and Associates, Inc.
4545 42nd Street, N.W.
Washington, D.C. 20016
Project Officer: Paul Lichtenstein
Division of Health Systems and Special Studies

Description: This is an evaluation of the effectiveness of the demonstration that expands Medicare and/or Medicaid coverage to freestanding alcoholism treatment centers. It will examine the impact of the demonstration on the use and cost of services. The project is supported by funds from the National Institute on Alcohol Abuse and Alcoholism, Public Health Service, and the Health Care Financing Administration.

Status: The research design was completed in March 1983. The contractor is currently implementing the research design. Data collection, analysis, and submission of interim and final reports will follow. The final report is due December 1986.

Beneficiary Awareness

Cost of Care Information to Consumers

Funding: The Rand/University of California, Los Angeles Health Financing Policy Research Center (See page 176)
Project Officer: John C. Langenbrunner, Division of Reimbursement and Economic Studies

Description: Recent changes in Federal reimbursement policy have contributed to a growing recognition of the importance of providing consumers with medical information on health care costs. A few programs providing such information have been in place for some time, and many more are being developed. The Federal Government is also concerned with increasing consumers' access to information that will enable them to make informed choices in the health care market. This study will begin to develop the data necessary to assess the value of programs to provide consumers with information about health care costs and to examine models for such programs. Consumer education efforts may improve market efficiency by increasing the level of information that consumers bring to decisionmaking. However, there are costs associated with communicating information to consumers. To assess the cost/benefit tradeoff requires information about present knowledge that consumers have, the impact of knowledge on decisionmaking, and the cost effectiveness of alternative dissemination policies. The objective is to gather existing evidence on these issues and to propose an agenda for future research. The research approach will proceed along two parallel lines. One approach is to analyze the existing empirical and theoretical literature concerning consumer decisionmaking and information processing in the health sector. The second approach is to survey current efforts to distribute information to consumers, emphasizing programs aimed at Medicare beneficiaries.

Status: The Social Security Amendments of 1983 (Public Law 98-21) require that a report be submitted to the Congress by April 1985 on the "advisability of having hospitals make available information on the cost of care to patients financed by both public programs and private payers." The Health Care Financing Administrtation may utilize the findings of this study in developing that report.

Consumer as a Partner in Medical Cost Containment

Project No.: 500-84-0063
Period: October 1984 - April 1985
Funding: $ 31,003
Award: Contract
Contractor: KENEKO Communications
1700 Mission Street, Suite 204
Santa Cruz, Calif. 95060
Project Officer: Dave Schwartz
Division of Research and Demonstrations Systems Support

Description: This project is authorized under the Small Business Innovation Development Act of 1982 (Public Law 97-219). The project is to develop a medical guide that will give information and assistance to consumers. Phase I will consist of obtaining commitments from test sites, the development of test measures, the development of testing programs, and examination of base-line data at the test sites.

Status: The project began on October 1, 1984. The work to be performed is in the design and early developmental stages.

Health Care Services for Children Under Medicaid

Project No.:	18-P-98011/3
Period:	August 1981 - October 1985
Funding:	$ 504,311
Award:	Grant
Grantee:	Johns Hopkins University School of Medicine Department of Pediatrics 720 Rutland Avenue Baltimore, Md. 21205
Project Officer:	Benson Dutton Division of Reimbursement and Economic Studies

Description: This is a grant for a comparative study of health care services for children by using billing claims and eligibility data files from the State of Maryland. The grantee seeks information on the cost and effectiveness of services for children eligible for the Medicaid Early and Periodic Screening, Diagnosis, and Treatment Program. Data on the costs and utilization of services for children using private practitioners, hospital clinics, emergency rooms, and various combinations of delivery systems serve as the basis for this analysis.

Status: Using the data files for the Johns Hopkins Hospital Title V, Children and Youth Clinic, use of services by Medicaid and self-pay patients have been compared. Within an organized program, differences were small. The implications of these findings were explored, particularly in light of other studies. Services for children with asthma were studied in the Children and Youth Project (C&Y) and in the middle class population of the Columbia, Maryland Medical Plan. Services were far more numerous and thus, more costly for the C&Y Medicaid population than for Columbia. The monitoring of Medicaid services including diagnosis-specific studies for other chronic and acute problems with cost containment as the goal will be tested against the large State Medicaid file.

Prenatal Care and Its Relationship to Medicaid Costs

Project No.: 11-P-98305/7-02
Period: March 1983 - December 1984
Funding: $ 78,679
Award: Grant
Grantee: Missouri Division of Health
Broadway State Office Building
P.O. Box 570
Jefferson City, Mo. 65102
Project Officer: Benson Dutton
Division of Reimbursement and Economic Studies

Description: This project linked birth certificate records with Medicaid obstetrical and newborn records. The combined data set was used to study the obstetrical and newborn Medicaid costs associated with women who receive preventive prenatal services as opposed to those who do not receive adequate services. The primary goal of the project was to determine if the Medicaid coverage provided for Medicaid mothers obtaining adequate prenatal care is cost beneficial.

Status: Preliminary findings from this study suggest that there is a net increase in Medicaid costs by providing adequate prenatal care. However, the costs of providing adequate prenatal care are small when compared with the overall Medicaid budget for mothers and newborns. The reduction in low-birth-weight rates and possible reduction in neonatal mortality among the babies of mothers with adequate prenatal care suggest that this is a worthwhile investment. The final report is available from the National Technical Information Service, accession number PB85-195352/AS.

Other Prevention

Municipal Health Services Program

Period:	August 1979 - December 1985
Award:	Cooperative Agreement
Participants:	Baltimore, Md. Cincinnati, Ohio San Jose, Calif. St. Louis, Mo. Milwaukee, Wis.
Project Officer:	Shelagh Smith Division of Health Systems and Special Studies

Description: Municipal Health Services Program (MHSP) is a collaborative effort of five major cities in five States, the U.S. Conference of Mayors, the Robert Wood Johnson Foundation (RWJF), and the Health Care Financing Administration (HCFA). It was initiated by RWJF through grants of $3 million awarded in June 1978 to each of the following five cities: Baltimore, Cincinnati, Milwaukee, St. Louis, and San Jose. HCFA joined in the project by providing Medicare waivers through a cooperative agreement and Medicaid waivers through grants to 4 of the 5 States to test the effects of increased utilization of municipal health centers by:

- Eliminating coinsurance and deductibles.
- Expanding the range of covered services.
- Paying the cities the full cost of delivering services at the clinics.

The intent of the waivers is to shift fragmented utilization away from costly hospital emergency rooms and outpatient departments toward lower cost Municipal Health Services Program (MHSP) clinics which would provide beneficiaries with comprehensive primary and preventive health care.

Status: The first city began billing under the Medicare waiver in August 1979. Four of the five cities (all except Cincinnati) desired to use Medicaid waivers as well, and this brought in participation of the State governments in 1981. As of June 1984, the five MHSP cities have a total of 19 clinics operating, bringing together both public and private health-related organizations. A wide variety of services are offered, including medical, social, mental, preventive, dental, pharmacy, optometry, podiatry, and rehabilitation. Clinic utilization ranges widely from 700 visits per year to 40,000 visits per year. Average provider productivity ranges from 3,200 to 4,500 annual visits per full-time equivalent provider. Waivers were scheduled to terminate December 31, 1984; however, in response to proposals from four of the cities (St. Louis chose not to request an extension) to go at full risk and capitate Medicare Part A and B services in 1986, HCFA has agreed to extend the Medicare waivers one additional year, through December 1985.

Evaluation of Municipal Health Services Program

Project No.: 500-78-0097
Period: September 1978 - March 1985
Funding: $ 3,105,250
Award: Contract
Contractor: University of Chicago
5720 S. Woodlawn Avenue
Chicago, Ill. 60637
Project Officer: Tony Hausner
Office of Demonstrations and Evaluations

Description: This is an evaluation of the Municipal Health Services Program demonstrations. It is a collaborative effort with the Robert Wood Johnson Foundation. The evaluation covers the quality and efficiency of services delivered in urban clinics in five cities (Baltimore, Cincinnati, Milwaukee, St. Louis, and San Jose).

Status: The contractor has submitted interim reports covering the baseline survey and secondary data resources. The final report, which will include data from the followup survey, is expected in Spring 1985. Preliminary findings indicate that program users have lower health care utilization than other users in the service area.

Quality and Effectiveness of Preventive Medical Care

Project No.: 18-P-97777/9
Period: September 1980 - January 1985
Funding: $ 596,804
Award: Grant
Grantee: The Rand Corporation
1700 Main Street
Santa Monica, Calif. 90406
Project Officer: Benson Dutton
Division of Reimbursement and Economic Studies

Description: This study focuses on the effect of preventive care on various categories of medical expenditure and any losses attributed to sickness. Issues and questions to be addressed include:

- The effects of preventive care on health status, medical care use, and work time available.
- The responsiveness of consumer demand to changes in the price of preventive care.
- The amounts of preventive care used in prepaid systems versus fee-for-service practice settings, both with no out-of-pocket charges.
- Whether or not people choosing the prepayment plan are fundamentally different in their desires to obtain preventive care.

The study will use data from the Rand Health Insurance Study (HIS), a social experiment in which families are assigned to several different health insurance plans. Approximately 8,000 individuals have been enrolled at six sites across the country: Dayton, Ohio; Seattle, Wash.; Fitchburg, Mass.; Franklin County, Mass.; Charleston, S.C.; and Georgetown County, S.C.

Status: To date, this project has produced analyses of the frequency and cost of medical visits involving nonpreventive care and hospitalizations. Findings from this analysis indicate no significant effect of aggregate preventive activities on aggregate nonpreventive care, hospital visits, and costs. These findings were presented at the Conference on Productivity in Health, Stanford University, August 1983 and the Third International Conference on System Science in Health Care, Munich, Germany, July 1984.

Prevention of Future Utilization of Health and Long-Term Care Services

Project No.:	18-P-98288/3-02
Period:	March 1983 - March 1986
Funding:	$ 737,000
Award:	Grant
Grantee:	Johns Hopkins University School of Hygiene and Public Health 615 North Wolfe Street Baltimore, Md. 21205
Project Officer:	Shelagh Smith Division of Health Systems and Special Studies

Description: Johns Hopkins is evaluating an intervention project conducted at New York University Hospital, entitled "Cooperative Care" in which chronically ill Medicare beneficiaries and their care partners are trained in self-care techniques. The purpose of the project is to reduce the high rate of post-discharge rehospitalizations for certain chronic conditions (e.g., heart disease) through good home care monitoring. Cooperative Care, a 4-day inpatient education program, emphasizes the care partner's role in reinforcing patients to take their medication and to adhere to diet and exercise regimens.

Status: Since the beginning of the study, 456 patients plus 456 care partners have been randomly assigned to either the experimental or control group. Approximately 80 percent of the experimental patients are transferred into Cooperative Care from New York University Hospital, and the other 20 percent are directly admitted to the program. Approximately 456 patients (plus their care partners) in the study have completed the first followup questionnaire (2 weeks), and more than 280 pairs have completed the 6-month followup questionnaire. For the 9-month utilization followup, 164 patients have been contacted; for the 12-month utilization followup, 145 patients have been interviewed. The project will continue through March 1986.

Trends in Pediatrician Participation in State Medicaid Programs

Project No.: 18-P-98265/5-01
Period: March 1983 - April 1985
Funding: $ 232,296
Award: Grant
Grantee: American Academy of Pediatrics
Department of Health Services Research
1801 Hinman Avenue
Evanston, Ill. 60204
Project Officer: Benson Dutton
Division of Reimbursement and Economic Studies

Description: The overall goal of this study is to measure and analyze trends in physician participation in Medicaid and the Early and Periodic Screening, Diagnosis, and Treatment program in the 13 States that were studied by the Health Care Financing Administration in 1979. The study will also identify and recommend State-specific policy strategies for fostering the participation of primary care physicians in Medicaid, thereby promoting access of children to appropriate and efficient sites of preventive and acute care.

Status: The survey of physicians undertaken during the first year of this project has been completed. The completed questionaires are being processed. Phone calls to nonrespondents are being made to gather information for the response analysis. Development of descriptive statistical reports, for panel and sample, for each of the 13 study States, and replication of the 1979 multivariate analysis of determinants of pediatrician participation in Medicaid has begun. Project staff are currently conducting analyses of competition and its affects on Medicaid participation. Findings from the project were presented at the 1984 American Public Health Association Annual Meeting. A final report is expected in 1985.

INDEX TO CONGRESSIONALLY MANDATED STUDIES

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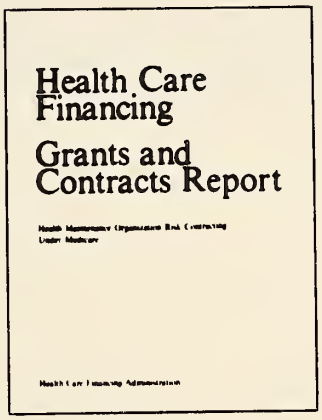
What's new in health care financing?

HCFA publishes a "how-to" study on Medicare risk contracting

Health Maintenance Organization Risk Contracting Under Medicare addresses operational issues and strategies for health maintenance organizations and competitive medical plans interested in risk-based contracting with the Medicare program. Financial, marketing, health care delivery, and contract administration considerations are discussed.

An overview of eight Medicare capitation demonstrations, which began in 1980, is presented in a case-study format that reviews the problems, approaches, and results of each project.

Basic guidelines are provided on Medicare risk contracting under the Tax Equity and Fiscal Responsibility Act, including who is eligible to contract with the Health Care Financing Administration (HCFA) on a risk basis and the process of establishing a risk contract.



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